



House of Commons  
Health Committee

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# Annual accountability hearing with the General Medical Council

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**Eighth Report of Session 2010–12**

*Report, together with formal minutes, oral and  
written evidence*

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## The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

### Committee staff

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<sup>1</sup> Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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# 1 Introduction

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1. The General Medical Council (GMC) is the independent regulator of doctors in the UK. Numerous predecessor organisations have existed since the Medical Act of 1858,<sup>2</sup> though the GMC and its current core functions were established by the Medical Act of 1983.<sup>3</sup> The four key functions of the GMC are:

- keeping up-to-date registers of qualified doctors;
- fostering good medical practice;
- promoting high standards of medical education and training; and
- dealing firmly and fairly with doctors whose fitness to practise is in doubt.<sup>4</sup>

In undertaking these functions the GMC aims to be independent, fair, efficient and effective, to raise standards, to foster the professionalism of doctors and to command the confidence of key interest groups.<sup>5</sup>

2. The GMC is seen nationally and internationally as a robust, well-functioning regulator. The Commission for Healthcare Regulatory Excellence (CHRE) undertakes an annual review of the GMC and other regulators of health professions and publishes an annual review. In its annual review for the year 2010–11 the CHRE states that:

The GMC has maintained and in many ways improved its levels of good performance across all of its regulatory functions this year.<sup>6</sup>

In its written submission to the Committee, the CHRE stated that:

In CHRE's view, the GMC performs well. It demonstrates excellence in several areas across its regulatory functions against a background of significant change. The GMC has an impressive commitment to continuous improvement, even in areas where it was already performing to a good standard, and to addressing challenges in medical regulation.<sup>7</sup>

3. The Committee has not uncovered evidence to the contrary. The GMC's financial performance is good and it is making progress across a range of issues, including many of those we identified in our earlier report on the revalidation of doctors.<sup>8</sup>

**4. Although, therefore, the Committee recognises that the GMC achieves a high level of operational competence, it remains concerned that the leadership function of the GMC**

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2 Medical Act 1858

3 Medical Act 1983

4 "The role of the GMC", GMC website, 2011, [www.gmc-uk.org](http://www.gmc-uk.org)

5 Ev 18

6 The Council for Healthcare Regulatory Excellence, *Performance review report 2010–11*, HC 1084-II, June 2011

7 Ev 44

8 Health Committee, Fourth Report of Session 2010–12, *Revalidation of Doctors*, HC 557

**within the medical profession, and within the wider health community, remains underdeveloped particularly in the areas of fitness to practise, revalidation, education and training and voluntary erasure. We hope that the GMC will embrace more ambitious objectives for professional leadership, some of which are described in this report.**

## 2 Revalidation of doctors

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5. As we stated in our earlier report on this matter, revalidation is:

[...] a broad term used to refer to the policy of proactively ensuring that practitioners who are registered to practise are still safe and competent to do so. This contrasts with the policy of investigating competence only when complaints are made or concerns are raised.<sup>9</sup>

6. As we made clear in our earlier report, the Committee attaches considerable importance to the role of the GMC as the “owner” and “leader” of the debate about revalidation. The Committee welcomes the Government’s support for revalidation, and its willingness to facilitate its implementation; prime responsibility for planning and executing effective and timely revalidation does however, in the Committee’s view, rest squarely on the shoulders of the GMC.

7. In his memorandum of evidence to the Committee, the former President of the GMC, Sir Donald Irvine has flagged up a number of issues with the proposed system of revalidation as it stands. He alleges that the bar used by the GMC to establish good or problematic practice (in the GMC document *Good Medical Practice*<sup>10</sup>) in the context of revalidation “is set too low to protect patients properly”.<sup>11</sup> In terms of revalidation, Sir Donald states that:

In her final report [into the case of Harold Shipman] Dame Janet Smith said that “the reality of the ‘remarkably low’ standard above which doctors will be revalidated does not square with the claim that revalidation gives an assurance that the doctor is ‘up to date and fit to practise’”. Now, nearly eight years on, nothing seems to have changed. This is why urgent action is required.<sup>12</sup>

Whether this bar is set too low will be explored further in the chapter on fitness to practise (chapter 3).

8. Sir Donald goes on to highlight the work undertaken by the Society of Cardiothoracic Surgery of Great Britain and Ireland. All cardiothoracic surgical interventions in the UK are subject to peer benchmarking, the results of individual surgeons are published and the standards used for this are the standards that will be adopted for revalidation of cardiothoracic surgeons.<sup>13</sup> He recommends that the process used by this organisation be adopted by the GMC and the medical royal colleges in their work on revalidation.

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9 Health Committee, Fourth Report of Session 2010–12, *Revalidation of Doctors*, HC 557, p5

10 General Medical Council, *Good Medical Practice*, 2006

11 Ev 25

12 Ev 28

13 Ev 28

9. In its evidence to the Committee the GMC stated that they are engaging with the cardiothoracic surgeons on their work, so that they can learn from this with a view to refining the process of revalidation.<sup>14</sup> However, they also point out that:

[...] obviously it is easier, in some ways, to measure outcomes in cardiothoracic surgery than it is, for example, in general practice or psychogeriatrics.<sup>15</sup>

10. The GMC also points out that revalidation must commence in 2012 as previously agreed and that:

[...] we certainly would not subscribe to a view that you cannot start revalidation until you have, for example, the level of outcome results which cardiothoracic surgeons achieve because, frankly, we would be sitting here in 20 years' time still talking about why we do not have revalidation as a profession.<sup>16</sup>

**11. The work undertaken by the Society of Cardiothoracic Surgery of Great Britain and Ireland in setting standards for that part of the medical profession is commendable. Its transparency will be welcomed by patients and should be a template (where clinically relevant) for further refinement of the revalidation process.**

**12. The GMC clearly has a considerable amount of work to undertake between now and the implementation of revalidation in 2012. Although we agree that all disciplines will not have developed their standards to an advanced level by that date, the GMC needs to accelerate its work with the medical royal colleges to further refine the standards for revalidation in specialist areas and to ensure that the process is meaningful to clinicians and transparent to the public.**

13. Although it is reasonable to expect that the majority of doctors will meet the standards required for revalidation, it is likely that some doctors will require retraining, or some other form of remediation in order to meet the standard, and that some doctors may not achieve revalidation. In evidence to us, the GMC stated that:

[...] revalidation is an imponderable because there may be doctors who decide, "I don't want to go through this. I am going to retire," and give up practice. There are all those things and, inevitably, like everybody else, we can only see so far ahead [...]<sup>17</sup>

**14. As the GMC states, some doctors may decide to retire rather than undergo the process of revalidation; of those who pursue revalidation, some may require retraining and some may fail to meet the required standards. The GMC needs to ensure that it monitors the number of doctors who retire, leave the profession, have conditions placed on their practice or fail revalidation. It must develop and share this evidence with employers to ensure that future workforce planning includes the developing outcome of the revalidation process.**

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14 Q 16

15 *Ibid.*

16 *Ibid.*

17 Q 64

15. A pilot programme of enhanced appraisal and revalidation involving over 3,000 doctors, their appraisers plus Responsible Officers and others has been in operation since 2010. An independent review of this programme has been recently published.<sup>18</sup> There was an improved sense that enhanced appraisal improves care. However, when surveyed on whether appraisal and revalidation will enhance early warning of doctors with performance issues, only 32% of Responsible Officers agreed, the remainder either disagreed (26%) or were neutral.<sup>19</sup> Just over half of Responsible Officers (58%) were happy to recommend revalidation of a doctor based on the information they had.<sup>20</sup> **Of the Officers who will have to make recommendations about revalidating doctors, only a minority feel that the process will help with the early identification of doctors with performance issues. Early identification of problem doctors is a core task of the professional regulatory system, and the GMC needs to ensure that its systems of appraisal and revalidation achieve this task.**

16. The Committee notes the recent media reports that the current IT system used in the revalidation pilots is “unworkable” and should be scrapped, and that doctors were “overwhelmed by the workload”.<sup>21</sup> Although this IT system may not be the final version deployed when revalidation goes live, the doctors undergoing the pilot processes have stated that “I spent over 40 hours on the process” and that it is “incredibly work-intensive”.<sup>22</sup>

17. Media reports about the proposed revalidation system may have over-stated the time it will take to complete the revalidation process. The revalidation evaluation states that the median time it took a doctor to collate the information required for enhanced appraisal was 15 hours, and the report states that this is less than 1% of a doctor’s annual working hours. It does add however, that doctors found it difficult to provide evidence of showing respect for patients, treating patients and colleagues fairly and without discrimination, and acting with honesty and integrity.<sup>23</sup> Appraisers also found it difficult to make a judgement on these attributes. Furthermore, locum doctors are experiencing difficulty in collecting the information required for revalidation.

**18. The Committee notes the negative media reports about the time taken to undertake revalidation and hopes that the GMC will ensure that lessons are learned from the revalidation pilots, particularly in how it can support locum doctors. It also needs to ensure that the underlying processes that doctors are expected to undertake are not unwieldy and overly time-consuming, and that they are an effective means of gathering the required evidence.**

19. Also in our earlier report on revalidation, the Committee highlighted the problems with UK law and an EU directive that prevent the GMC from testing the language skills of

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18 Department of Health Revalidation Support Team, *Independent Evaluation of the Medical Revalidation Pathfinder Pilot, final report*, 15 July 2011

19 *Ibid*, p32

20 *Ibid*. p3

21 “Revalidation pilots find process unworkable”, *The Pulse*, 22 June 2011

22 *Ibid*.

23 Department of Health Revalidation Support Team, *Independent Evaluation of the Medical Revalidation Pathfinder Pilot, final report*, 15 July 2011 p17

doctors coming from the EEA and Switzerland to practice in the UK.<sup>24</sup> A separate but equally important issue relates to the fact that qualifications may appear to be equivalent across Europe, yet may actually mean very different things in practice. The Committee recommended that the GMC report to Parliament what additional powers it requires to fulfil its function effectively. In oral evidence to the Committee, Niall Dickson, the Chief Executive and Registrar of the GMC told us:

As far as Europe is concerned—and I have said this before to this Committee—obviously we have concerns. A lot of concentration has been on language as the issue but we have concerns because we have no means of checking the competence of doctors who are coming from the European Union, as the arrangements stand at the moment. If those doctors have a certificate of good standing from a competent authority within the European Union, we have to admit them.<sup>25</sup>

20. The GMC has been working on this issue and has stated that:

[...] I think we have made very good progress. As everybody is aware, it is a complex and difficult area. With colleagues from the DH, we are at the final stage of finalising a scheme which would provide much better safeguards, both in terms of language and, indeed, in terms of competence, than the current arrangements allow. [...] The scheme would have a link back so that, when somebody first comes on who is new to the register, they engage with the Responsible Officer. They would then have a link back to the GMC where the Responsible Officer would sign off that that doctor was competent and fit to practise. We think we have made considerable progress. Some of the detail is still being thought through, but we believe it is compliant with European law, and that, if we can get UK law changed, it will be compliant with UK law as well.<sup>26</sup>

The GMC went on to say that its proposals are now with the Department of Health for Ministerial decision.<sup>27</sup>

**21. Doctors from the European Economic Area and Switzerland seeking to practice in the UK cannot routinely be language and competence tested by the GMC.**

**22. The GMC along with the Government is working towards resolution of this with partner organisations across Europe. The Committee takes the view that current legal framework is at odds with good clinical practice, which is clearly unacceptable. The GMC has plans, within the boundaries of UK law and the EU Directive, to manage the constraints on language and competence testing by using the Responsible Officer role to establish that EEA (the EU plus several other European countries) doctors are fit to practise in the UK. The Committee accepts this way forward as a short term measure.**

**23. Although this short term measure is welcome, the Committee believes that public confidence in the medical profession requires the issue to be addressed authoritatively.**

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24 Health Committee, Fourth Report of Session 2010–12, *Revalidation of Doctors*, HC 557, p20

25 Q 29

26 Q 30

27 *Ibid.*

**It is clearly unsatisfactory that the competence to practise of health professionals should be assured by a work-around, and we look to the Government, GMC and the relevant European bodies to work as a matter of urgency to produce a long-term solution to this problem.**

### 3 Fitness to practise

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24. The GMC accepts complaints about a doctor's fitness to practise from patients, members of the public and from within the profession itself. Independent fitness to practise panels are convened to inquire and come to a decision on any sanction to be applied. They comprise medical and lay members, with the doctor and the GMC itself represented by a legal counsel. The panel may decide to accept undertakings from the doctor e.g. to retrain, to place conditions on the doctor's registration (e.g. that they do not undertake specific procedures), or to suspend or erase the doctor from the register.<sup>28</sup>

25. In their evidence to the Committee the GMC stated that there had been a significant increase in the number of fitness to practise inquiries:

We experienced a 24% increase in the number of enquiries about a doctor's fitness to practise in 2010 compared to 2009. This increase led to a 19% increase in the caseload for enquiries that appear to require a GMC investigation into potentially serious concerns. We have responded to this by increasing our investigation resources and improving our efficiency and productivity.<sup>29</sup>

26. The Nursing and Midwifery Council, the regulator of the nursing and midwifery professions, has also seen a marked increase in referrals, as has the NHS complaints system.<sup>30</sup>

**27. The Committee notes that there is an increase in referrals of doctors to the GMC, and of nurses to the NMC, as well as an increase in the number of general NHS complaints. The Committee welcomes the fact the GMC has commissioned research into this phenomenon in order to better understand what is driving this increase, and to ensure that their systems and processes are adequate for meeting the future needs of the public. We look forward to reviewing the preliminary findings of this with the GMC at our next accountability hearing.**

28. Despite this significant rise in cases, the GMC continues to meet the target to conclude 90% of fitness to practise cases within fifteen months, set for it by the Council for Healthcare Regulatory Excellence (CHRE), the regulator of health professions regulators.<sup>31</sup> The GMC accepted that the target had been met but went on to say:

I still think that is too long and that there are cases going too long, which is why our fitness to practise reforms are designed to speed up this process.<sup>32</sup>

**29. The Committee welcomes the ongoing good performance of the General Medical Council (GMC) in resolving 90% fitness to practise cases within fifteen months.**

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28 "The investigation process", GMC website 2011, [www.gmc-uk.org](http://www.gmc-uk.org)

29 Ev 20

30 Health Committee, Seventh Report of Session 2010–12, *Annual accountability hearing with the NMC*, HC 1428, and Health Committee, Sixth Report of Session 2010–12, *Complaints and Litigation*, HC 786-I

31 Ev 44

32 Q 62

**However, we agree with the GMC that fifteen months is indeed too long to conclude such cases and we recommend that the Council for Healthcare Regulatory Excellence (CHRE) their regulatory body, should set the GMC a more demanding target for future years.**

30. In his memorandum of evidence to the Committee, the former President of the GMC, Sir Donald Irvine recommended that the Committee view the processes of revalidation and fitness to practise as one system that aims to ensure public protection.<sup>33</sup> Sir Donald raised a number of concerns with this system, the core allegation being that:

The baseline (the bar) used today by the GMC to distinguish between good and problematic practice in its fitness to practise procedures—and revalidation when it is introduced—is too low to protect patients properly. It must be raised, to reflect the GMC’s commitment to the public, set out in the introduction to its guidance Good Medical Practice, which tells patients that the standards described are what ‘they can expect’ from doctors registered with the GMC. It is necessary also to protect the good name of the profession.<sup>34</sup>

31. Sir Donald explained that:

The first point to emphasise is that, with Good Medical Practice as the foundation guide, British university medical schools and the GMC have together set a high bar for entry to the medical profession [...]The problems really begin with established doctors. It is important to understand why. Historically the standard of practice followed by doctors throughout the remainder of their careers has been and still is down to individual conscience in the exercise of professional autonomy, with the onus on the GMC to prove that a doctor may be in breach. [...]In the 2008 the RCGP publication Good Medical Practice for General Practitioners distinguished between exemplary and unacceptable criteria for revalidation, which was a step forward. Nevertheless, the GMC has never said where the bar should be for use by panels hearing fitness to practise cases, despite the persistent efforts of some of us to get it to do so. *Not surprisingly, therefore, some doctors are allowed to continue to practise, possibly with conditions, at a level well below that required by the GMC, the universities, the medical royal colleges and specialist societies to get onto the medical register and qualify as a specialist or principal in general practice in the first place (our emphasis).*<sup>35</sup>

32. In response to this, the GMC stated that:

We are saying no, that we do not think we have set the bar at the wrong level. Indeed, in these cases, we pointed to what action we thought should happen.<sup>36</sup>

They argued that the bar for fitness to practise is established in the document Good Medical Practice and whether “a doctor acted reasonably”.<sup>37</sup> They went on to state:

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33 Ev 29

34 Ev 25

35 Ev 27–28

36 Q 5

We work very closely with the Royal Colleges and it is the Royal Colleges that set the clinical standards, as it were. Thus, implicitly, the experts or the performance assessors we use are using Royal College guidance time and time again and we work closely with the Royal Colleges to make sure that they are up to date.<sup>38</sup>

33. Sir Donald also informed us of several fitness to practise cases where he felt the GMC panels had been unduly lenient, examples of what he calls “the low bar” for demonstrating fitness to practise.<sup>39</sup> For example, he highlighted one case where serious problems were identified over a number of years with the practice of a gynaecologist:

The panel, finding misconduct, said that his conduct ‘fell far below the standards expected of all registered practitioners’. They went on to say that the recorded behaviour would be ‘regarded as deplorable by the public, patients and fellow practitioners’ [...] They concluded that his conduct, although ‘falling far below the standard of a registered medical practitioner, is not fundamentally incompatible with continued registration’.<sup>40</sup>

The contradiction in logic of the decision made by this panel is clear and may highlight performance issues with GMC fitness to practise panels. Other examples of undue leniency have also been brought to the attention of the Committee.

34. Fitness to practise panels are a part of the GMC but are independent within its governance structures. The previous Government had planned that the adjudication of fitness to practise cases would pass to the Office of the Health Professions Adjudicator (OPHA), an entirely separate and new organisation. The Coalition Government has decided not to progress with the transfer of this function to OPHA<sup>41</sup> and instead the GMC has been consulting on the formation of an internal but more separate Medical Practitioner Tribunal Service (MPTS). The MPTS will be under the supervision of a “senior judicial person” who will performance manage panellists.<sup>42</sup>

**35. Some of the decisions made by fitness to practise panels of the GMC defy logic and go against the core task of the GMC in maintaining the confidence of its stakeholders. Furthermore, they put the public at risk of poor medical practice.**

**36. The GMC holds the dual but potentially conflicting roles of prosecutor and adjudicator in fitness to practise cases. The GMC proposes to establish an Independent Medical Practitioner Tribunal Service to create a greater separation between these functions, and the Committee supports this proposal. We also urge that performance management of fitness to practise panellists commence as soon as is practicable.**

37. The GMC staff told the Committee that GMC panellists agree with their recommendations in approximately 84% of cases.<sup>43</sup> When GMC panels do not agree with

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37 Q 24

38 *Ibid.*

39 Ev 27–28

40 Ev 27

41 Ev 15

42 Q 12

43 Q 5

GMC staff, the CHRE has the right to appeal against that decision on the grounds of undue leniency.<sup>44</sup> The GMC itself has no right appeal against panel decisions but has recently consulted on obtaining such a right and will bring a proposal to the Government shortly.<sup>45</sup>

38. In their written submission to the Committee, the CHRE has told us that it opposes the GMCs proposed power of appeal:

In our view, rather than establishing a sense of independence, we believe it would undermine public confidence in regulation if the GMC was to acquire this power to appeal. There would appear to be a financial and reputational disincentive for the GMC to appeal tribunal decisions, as the costs on both sides would be funded by registrants and any appeal could reflect negatively upon the MPTS. It would also unnecessarily duplicate the powers that CHRE hold in this area.

It cannot be an appropriate use of resources, or a satisfactory development of roles and responsibilities, if two organisations are given the power to appeal the same decision on the same grounds and it offers a considerable potential for confusion in the future. We can see no benefit in the GMC holding this power, either for those involved in the individual cases, for wider public confidence in the GMC or for the sector as a whole.<sup>46</sup>

39. The Committee notes the CHRE opposition but challenges the logic of there being “a financial and reputational disincentive” for the GMC to appeal. Rather, the GMC appealing against panel decisions will support its reputation with the public. This reputation is put at risk at the moment by its inability to challenge panel decisions it feels to be too lenient.

**40. The GMC currently has no right of appeal over decisions made by independent fitness to practise panels. The Committee does not seek to undermine the existing power of appeal held by the Commission for Healthcare Regulatory Excellence, but agrees that the GMC needs also to have a right of appeal in cases where it thinks panellists have been too lenient. We urge the Government to move quickly to make the necessary legislative amendments.**

41. The Committee also discussed with the GMC the cases of doctors who were involved in delivering or supervising care at the Winterbourne View care home near Bristol, which is currently under investigation by the police and number of regulatory bodies, and at the Mid Staffordshire NHS Foundation Trust, which is subject to an ongoing public inquiry.

42. The GMC has told us that between 120 to 150 doctors must have known something was going badly wrong at Stafford Hospital yet few raised concerns through the proper channels. They stated that:

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44 *Ibid.*

45 Ev 22

46 Ev 46

There were people who did blow the whistle and there were doctors who took action absolutely appropriately, did the right things and followed our guidance, but it is clear that large numbers of doctors did not.<sup>47</sup>

The GMC is investigating a number of doctors in relation to practice at Mid Staffordshire NHS Foundation Trust, some of who are under investigation purely for failure to raise concerns about other doctors.<sup>48</sup> The GMC also told us that:

In relation to the Mid Staffordshire cases, we have put them on hold pending the outcome of the Inquiry—again, not affecting patient safety—we will take action there—but concluding the cases. We think it is appropriate to wait until whenever the Inquiry is concluded because there have been things about individual practitioners that have emerged during the evidence.<sup>49</sup>

**43. Doctors from Mid Staffordshire NHS Foundation Trust whose practice was in itself blameless but who failed to act and raise concerns about colleagues are now also under investigation by the GMC. A clear signal needs to be sent by the GMC to doctors that they are at as much risk of being investigated by their regulator for failing to report concerns about a fellow registrant as they are from poor practice on their own part.**

**44. The Committee recognises, however that doctors and other practitioners who have raised concerns by other staff have sometimes been subject to suspension, dismissal or other sanctions.<sup>50</sup> The Committee therefore intends to examine this issue in more detail in due course.**

**45. In contrast to the approach of the Nursing and Midwifery Council, the GMC has put its fitness to practise cases relating to Mid Staffordshire “on hold” until the inquiry has concluded. The Committee believes that this is neither fair to the public, or to the registrants under investigation. We urge the GMC to set out its rationale for this, publically and clearly.**

### Pro-active regulation

46. In their evidence to us during their accountability hearing the Nursing and Midwifery Council described their proposals for a more proactive approach to regulation under which the NMC plan to undertake reviews of practice without waiting for an individual referral. Their critical standards intervention project is an attempt to deal with problem areas before referrals have been made to them about individual practitioners.<sup>51</sup>

47. The GMC is exploring this issue in a different manner and has recruited a network of advisers to work with employers across the UK, the Employer Liaison Team which

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47 Q 58

48 Q 60

49 Q 62

50 “Hung out to dry: scandal of the abandoned NHS whistleblowers”, *The Independent*, 4 July 2011

51 Health Committee, Seventh Report of Session 2010–12, *Annual accountability hearing with the NMC*, HC 1428, p15

supports medical directors and Responsible Officers with their concerns about individual doctors and when to refer cases to the GMC.<sup>52</sup> The Committee welcomes this development.

48. Clearly, the circumstances for the NMC and GMC are very different. The GMC regulates approximately 230,000 professionals for a fee of roughly £420. The NMC regulates nearly 700,000 practitioners across two professions for a relatively small registration of £76 and therefore modest resources. This makes a lighter-touch approach to regulation necessary given its burden and its resources. However, in principle, we believe that it is right that regulatory authorities should not merely react to poor practice but should, where possible, pre-empt it. Additionally, regulators should use intelligence from the field to identify systemic issues, such as arose at Mid Staffordshire NHS Foundation Trust, for example. As we note in our report on the NMC, its approach to investigation of, or intervention in a healthcare organisation where concerns are being raised is creative and interesting, and could offer the GMC another tool to strengthen public protection.

**49. We suggest that the GMC further considers risk-based approaches to proactive regulation and how these could be developed with its employer liaison services.**

## Minority and Overseas Doctors

50. In 2009, the GMC Black and Minority Ethnic (BME) Doctors Forum stated that doctors from black and minority ethnic groups were over-represented in the most serious fitness to practise statistics. Doctors from BME group are also more likely to be erased from the medical register than white doctors.<sup>53</sup> BME doctors and nurses are more likely to be referred to their regulators and to be on long term suspension.<sup>54</sup>

51. In response, the GMC told the Committee about its concerns in this area. It has undertaken research in order to understand this issue and has so far found that the issue relates to doctors who qualified overseas, and not to the ethnicity of the doctors concerned. They told us that:

If we look out on doctors from ethnic minorities who are UK trained, that is not on our radar. The issue of where you are trained seems to be a more important factor.<sup>55</sup>

In supplementary evidence to us the GMC stated that:

Recent research undertaken by Professor Charlotte Humphrey of Kings College, London, concluded that there is a clear link between whether a doctor qualified outside the UK and the likelihood of a ‘high impact’ fitness to practise outcome. The research also concluded that there is no clear association between ethnicity and outcome.<sup>56</sup>

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52 “GMC provides dedicated support for Responsible Officers”, *Revalidation Support website*, 3 July 2011, [www.revalidationsupport.nhs.uk](http://www.revalidationsupport.nhs.uk)

53 “Alarm over ethnic profile of disciplinary statistics”, *BMA News*, 24 May 2011

54 The involvement of black and minority ethnic staff in NHS disciplinary proceedings, *The University of Bradford*, September 2010

55 Q 25

56 Ev 23–24

52. However, the GMC does acknowledge that it has more work to do:

In our limited way, we certainly want to look at whether we can provide induction support for doctors when they first come on to our register.<sup>57</sup>

There are bits of subtext to this question. For example, a higher proportion of overseas qualified doctors work in peripatetic locum situations. In moving around within the NHS and not belonging to one organisation, the threshold for referral might be lower because there is no local governance around that doctor when they move on. I do not have any facts on this in terms of the reality of the figures, but it is something that, anecdotally, stands out and we do need to look at.<sup>58</sup>

**53. The Committee appreciates the seriousness with which the GMC has treated the suggestion that doctors from black and minority ethnic backgrounds are over-represented in fitness to practise cases. The finding that this relates to overseas trained doctors and not ethnicity per se does not alter the fact that a problem exists.**

**54. The GMC needs, as matter of urgency, to do more to understand the risks associated with overseas-qualified doctors. It should offer timely induction and needs to assure itself that those doctors in peripatetic locum positions are adequately supervised and supported. If a doctor is not safe to practise in the UK then the GMC must ensure that they do not do so.**

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57 Q 25

58 Q 26

## 4 Voluntary erasure

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55. Voluntary Erasure (VE) is the process through which doctors can apply to have their names voluntarily deleted from the medical register. Doctors can apply for VE at any stage during a fitness to practise hearing, and applications are referred to a panel of one doctor and one lay examiner for consideration.<sup>59</sup> The GMC's own guidance states that:

Decision-makers should not generally consider any application for voluntary erasure until the investigation has concluded and all of the evidence has been gathered in relation to the allegations. Decision-makers should be satisfied that it is right in all the circumstances to agree to voluntary erasure (and not to proceed with the inquiry proper) before any application is granted. 'All the circumstances' can be divided into three categories: the public interest, the private interest of the complainant and the private interest of the doctor.<sup>60</sup>

In most of the 2898 cases in which it was sought in the past year, VE was uncontroversial. We have heard of several cases where it has been controversial and may have damaged the public perception of the GMC.

56. The case of Owen Gilmore has been widely reported in the press.<sup>61</sup> Mr Gilmore was working in private practice where he was alleged to have administered inappropriate treatments and of removing breast tissue for which there was no clinical indication. He was also accused of financial misconduct. It has been alleged that the GMC took three years to schedule an investigation and when VE was applied for in November 2010 it then gave the relevant insurer 24 hours notice of Mr Gilmore's application for VE, which was then granted. In its public response to this case the GMC stated:

Our primary role is to ensure that those doctors on the medical register are fit to practise: however, in dealing with concerns our process must be fair to the doctor concerned.<sup>62</sup>

57. In oral evidence to the Committee the GMC told us:

In Dr Gilmore's case, the Case Examiners decided to accept an application for voluntary erasure based on his ill-health shortly before the hearing was due to open. The cases illustrate the often very complex legal hurdles that can arise in a process of prosecution of detailed factual charges and lengthy evidence before a quasi-judicial tribunal. Acceptance by the GMC of a doctor's application for erasure can achieve a quicker guaranteed outcome efficiently without the need to overcome such hurdles, and without the risk that the eventual outcome is less than erasure.<sup>63</sup>

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59 "Voluntary Erasure guidance", *GMC website*, 2011, [www.gmc-uk.org](http://www.gmc-uk.org)

60 *Ibid.*

61 "Insurers object to surgeon avoiding hearing", *Financial Times*, 1 November 2010

62 *Ibid.*

63 Ev 25

58. The GMC has been clear that VE is not a form of redress, but rather is another means of ensuring public protection:

We say that the purpose is to protect the public, not to provide some form of redress for patients. That is not to underplay the importance, as you say, of closure—it is a fine balancing act—but we think that where the doctor agrees to take an outcome which would fundamentally protect future patients, we should take that as long as there is a public audit trail of what the concerns were.<sup>64</sup>

59. However, the Committee also notes the submission from the Patients Association which relates to a GMC panel decision to decline the voluntary erasure of a doctor involved in the Baby P case:

After rejecting the request for voluntary erasure by Dr Al-Zayyat, the doctor in the Baby P case, the FTP panel chair Ralph Bergmann said: “The panel considers that to accede to the application for voluntary erasure would avoid a public, and necessary, examination of the facts.”<sup>65</sup>

60. Although the Committee accepts that voluntary erasure from the medical register can be used to prevent further malpractice by that registrant, an interim order can also be used to prevent a registrant from practising to protect the public whilst a case is under investigation.

**61. Several cases have been brought to the attention of the Committee of doctors applying to remove themselves from the register during an ongoing investigation into their practice by the GMC (so called voluntary erasure). The Committee has no objection to the principle of voluntary erasure as it can be a useful tool to protect the public. However, in some cases, interested parties have been given little or no time to raise an objection to applications for voluntary erasure, and the GMC was not able to offer a clear explanation of this.**

**62. Applications for voluntary erasure must not be granted by the GMC unless interested parties have been given adequate notice of an application and have been offered an opportunity to voice an opinion on the matter.**

63. The GMC is proposing that VE can be adapted. The GMC currently informs other regulators of its VE decisions, without a full explanation of the circumstances.<sup>66</sup> It also informs other regulators:

[...] where we know that the doctor is leaving the country. If the doctor were going to another country, we would tell the regulator that the doctor has taken voluntary erasure in the very specific circumstances we have decided to agree to that when there were still concerns about his practice.<sup>67</sup>

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64 Q 49

65 Ev 39

66 Q 50

67 Q 52

The GMC is seeking the power to publish the circumstances surrounding its VE decisions.<sup>68</sup> When asked by the Committee if this would amount to a “guilty plea”, the GMC responded that it would.<sup>69</sup>

**64. The Committee fully supports the publication of the facts of any case of voluntary erasure where there is a fitness to practise allegation about the doctor concerned. The GMC needs to ensure that turning voluntary erasure into an admission of guilt does not have a perverse impact in reducing the numbers seeking it and therefore erode public protection.**

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68 Q 50

69 Q 51

## Conclusions and recommendations

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### Introduction

1. Although, therefore, the Committee recognises that the GMC achieves a high level of operational competence, it remains concerned that the leadership function of the GMC within the medical profession, and within the wider health community, remains underdeveloped particularly in the areas of fitness to practise, revalidation, education and training and voluntary erasure. We hope that the GMC will embrace more ambitious objectives for professional leadership, some of which are described in this report. (Paragraph 4)

### Revalidation of doctors

2. The work undertaken by the Society of Cardiothoracic Surgery of Great Britain and Ireland in setting standards for that part of the medical profession is commendable. Its transparency will be welcomed by patients and should be a template (where clinically relevant) for further refinement of the revalidation process. (Paragraph 11)
3. The GMC clearly has a considerable amount of work to undertake between now and the implementation of revalidation in 2012. Although we agree that all disciplines will not have developed their standards to an advanced level by that date, the GMC needs to accelerate its work with the medical royal colleges to further refine the standards for revalidation in specialist areas and to ensure that the process is meaningful to clinicians and transparent to the public. (Paragraph 12)
4. As the GMC states, some doctors may decide to retire rather than undergo the process of revalidation; of those who pursue revalidation, some may require retraining and some may fail to meet the required standards. The GMC needs to ensure that it monitors the number of doctors who retire, leave the profession, have conditions placed on their practice or fail revalidation. It must develop and share this evidence with employers to ensure that future workforce planning includes the developing outcome of the revalidation process. (Paragraph 14)
5. Of the Officers who will have to make recommendations about revalidating doctors, only a minority feel that the process will help with the early identification of doctors with performance issues. Early identification of problem doctors is a core task of the professional regulatory system, and the GMC needs to ensure that its systems of appraisal and revalidation achieve this task. (Paragraph 15)
6. The Committee notes the negative media reports about the time taken to undertake revalidation and hopes that the GMC will ensure that lessons are learned from the revalidation pilots, particularly in how it can support locum doctors. It also needs to ensure that the underlying processes that doctors are expected to undertake are not unwieldy and overly time-consuming, and that they are an effective means of gathering the required evidence. (Paragraph 18)

7. Doctors from the European Economic Area and Switzerland seeking to practice in the UK cannot routinely be language and competence tested by the GMC. (Paragraph 21)
8. The GMC along with the Government is working towards resolution of this with partner organisations across Europe. The Committee takes the view that current legal framework is at odds with good clinical practice, which is clearly unacceptable. The GMC has plans, within the boundaries of UK law and the EU Directive, to manage the constraints on language and competence testing by using the Responsible Officer role to establish that EEA (the EU plus several other European countries) doctors are fit to practise in the UK. The Committee accepts this way forward as a short term measure. (Paragraph 22)
9. Although this short term measure is welcome, the Committee believes that public confidence in the medical profession requires the issue to be addressed authoritatively. It is clearly unsatisfactory that the competence to practise of health professionals should be assured by a work-around, and we look to the Government, GMC and the relevant European bodies to work as a matter of urgency to produce a long-term solution to this problem. (Paragraph 23)

### **Fitness to practise**

10. The Committee notes that there is an increase in referrals of doctors to the GMC, and of nurses to the NMC, as well as an increase in the number of general NHS complaints. The Committee welcomes the fact the GMC has commissioned research into this phenomenon in order to better understand what is driving this increase, and to ensure that their systems and processes are adequate for meeting the future needs of the public. We look forward to reviewing the preliminary findings of this with the GMC at our next accountability hearing. (Paragraph 27)
11. The Committee welcomes the ongoing good performance of the General Medical Council (GMC) in resolving 90% fitness to practise cases within fifteen months. However, we agree with the GMC that fifteen months is indeed too long to conclude such cases and we recommend that the Council for Healthcare Regulatory Excellence (CHRE) their regulatory body, should set the GMC a more demanding target for future years. (Paragraph 29)
12. Some of the decisions made by fitness to practise panels of the GMC defy logic and go against the core task of the GMC in maintaining the confidence of its stakeholders. Furthermore, they put the public at risk of poor medical practice. (Paragraph 35)
13. The GMC holds the dual but potentially conflicting roles of prosecutor and adjudicator in fitness to practise cases. The GMC proposes to establish an Independent Medical Practitioner Tribunal Service to create a greater separation between these functions, and the Committee supports this proposal. We also urge that performance management of fitness to practise panellists commence as soon as is practicable. (Paragraph 36)

14. The GMC currently has no right of appeal over decisions made by independent fitness to practise panels. The Committee does not seek to undermine the existing power of appeal held by the Commission for Healthcare Regulatory Excellence, but agrees that the GMC needs also to have a right of appeal in cases where it thinks panellists have been too lenient. We urge the Government to move quickly to make the necessary legislative amendments. (Paragraph 40)
15. Doctors from Mid Staffordshire NHS Foundation Trust whose practice was in itself blameless but who failed to act and raise concerns about colleagues are now also under investigation by the GMC. A clear signal needs to be sent by the GMC to doctors that they are at as much risk of being investigated by their regulator for failing to report concerns about a fellow registrant as they are from poor practice on their own part. (Paragraph 43)
16. The Committee recognises, however that doctors and other practitioners who have raised concerns by other staff have sometimes been subject to suspension, dismissal or other sanctions. The Committee therefore intends to examine this issue in more detail in due course. (Paragraph 44)
17. In contrast to the approach of the Nursing and Midwifery Council, the GMC has put its fitness to practise cases relating to Mid Staffordshire “on hold” until the inquiry has concluded. The Committee believes that this is neither fair to the public, or to the registrants under investigation. We urge the GMC to set out its rationale for this, publically and clearly. (Paragraph 45)
18. We suggest that the GMC further considers risk-based approaches to proactive regulation and how these could be developed with its employer liaison services. (Paragraph 49)
19. The Committee appreciates the seriousness with which the GMC has treated the suggestion that doctors from black and minority ethnic backgrounds are over-represented in fitness to practise cases. The finding that this relates to overseas trained doctors and not ethnicity per se does not alter the fact that a problem exists. (Paragraph 53)
20. The GMC needs, as matter of urgency, to do more to understand the risks associated with overseas-qualified doctors. It should offer timely induction and needs to assure itself that those doctors in peripatetic locum positions are adequately supervised and supported. If a doctor is not safe to practise in the UK then the GMC must ensure that they do not do so. (Paragraph 54)

### Voluntary erasure

21. Several cases have been brought to the attention of the Committee of doctors applying to remove themselves from the register during an ongoing investigation into their practice by the GMC (so called voluntary erasure). The Committee has no objection to the principle of voluntary erasure as it can be a useful tool to protect the public. However, in some cases, interested parties have been given little or no time to raise an objection to applications for voluntary erasure, and the GMC was not able to offer a clear explanation of this. (Paragraph 61)

22. Applications for voluntary erasure must not be granted by the GMC unless interested parties have been given adequate notice of an application and have been offered an opportunity to voice an opinion on the matter. (Paragraph 62)
23. The Committee fully supports the publication of the facts of any case of voluntary erasure where there is a fitness to practise allegation about the doctor concerned. The GMC needs to ensure that turning voluntary erasure into an admission of guilt does not have a perverse impact in reducing the numbers seeking it and therefore erode public protection. (Paragraph 64)

# Formal Minutes

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**Tuesday 19 July 2011**

Mr Stephen Dorrell, in the Chair

Rosie Cooper  
Dr Daniel Poulter  
Chris Skidmore

David Tredinnick  
Dr Sarah Wollaston

Draft Report (*Annual accountability hearing with the General Medical Council*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 64 read and agreed to.

*Resolved*, That the Report be the Seventh Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Tuesday 6 September at 10.00 am

## Witnesses

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**Tuesday 14 June 2011**

*Page*

**Niall Dickson**, Chief Executive and Registrar, **Paul Philip**, Deputy Chief Executive and Director of Standards and Fitness to Practise, and **Professor Malcolm Lewis**, Council Member, General Medical Council.

Ev 1

## List of printed written evidence

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1	Department of Health	Ev 13
2	General Medical Council	Ev 18
3	General Medical Council supplementary	Ev 22
4	Sir Donald Irvine	Ev 25
5	Academy of Medical Royal Colleges	Ev 30
6	Medical Protection Society	Ev 32
7	Healthcare Audit Consultants Ltd	Ev 33
8	Royal College of Surgeons	Ev 37
9	The Patients Association	Ev 38
10	Office of the Health Professions Adjudicator	Ev 42
11	Council for Healthcare Regulatory Excellence	Ev 43

## List of Reports from the Committee during the current Parliament

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The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

### Session 2010–12

First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)
Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)
Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429

# Oral evidence

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## Taken before the Health Committee

on Tuesday 14 June 2011

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper  
Yvonne Fovargue  
Andrew George  
Mr Virendra Sharma

David Tredinnick  
Valerie Vaz  
Dr Sarah Wollaston

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### Examination of Witnesses

*Witnesses:* **Niall Dickson**, Chief Executive and Registrar, **Paul Philip**, Deputy Chief Executive and Director of Standards and Fitness to Practise, and **Professor Malcolm Lewis**, Council Member, General Medical Council, gave evidence.

**Q1 Chair:** Good morning, gentlemen, and thank you for coming. Could I ask you, very briefly, to introduce yourselves so that we know exactly where you are coming from in terms of your responsibilities within the GMC?

**Niall Dickson:** I am Niall Dickson, the Chief Executive and Registrar. On my left is Professor Malcolm Lewis, who is Chair of our Continued Practice Board—which is also responsible for revalidations—a member of our Council and a practising GP. On my right is my Deputy, Paul Philip, who is also the Director of Standards and Fitness to Practise at the GMC. Could I say a word or two to kick us off?

**Q2 Chair:** Please do. Could I ask you to speak up, as the acoustics in this room are not great?

**Niall Dickson:** I shall try to do so. It was simply to say that the GMC welcomes the opportunity to go through this exercise with the Select Committee. Professional regulation has been through significant change over the last 10 years, moving away from what was described as professional self-regulation. That, therefore, makes it incumbent upon bodies like us to be clearly accountable. We are no longer accountable to the profession in the same way, although we work very closely with the profession, and our focus is very much on patient safety and improving medical practice. Therefore, accountability to Parliament is the right route. It was first mooted in the White Paper in 2007 and I chaired a group, before I went to the GMC, which recommended it as well. It is good to see it being brought forward and enacted in the current form.

**Q3 Chair:** Thank you for that. We certainly regard it as an important part of our responsibilities as a Select Committee. However, our time is reasonably brief this morning and I am going, if I may—with apologies, if it appears provocative—to jump straight in at the deep end. I think you have seen a submission that has been put to the Committee by Sir Donald Irvine, a past president of the GMC. It has very strikingly drawn attention to the fact that it would appear the standards required in the case of fitness to practise hearings—

and, therefore, questioned in the context of revalidation—are, in many cases, significantly lower than the standards required for a doctor to register to practise in the first place. Most members of the public would think that if you qualify you then see skill enhanced in later practice: you do not see skill levels falling to those which, if you practised them on the day you first qualified, would not entitle you to qualify. That is the core argument of Sir Donald's memorandum. I would be interested to hear how the GMC responds to it.

**Niall Dickson:** The first point is this. If it were true we applied, in our fitness to practise cases, a lower standard than that which required people to join the register in the first place, that would not be right. Two questions are raised by Sir Donald's memorandum. Can I say, first of all, that we have enormous respect for Sir Donald? We have an ongoing dialogue with him and I think we share the ambition of where we are all going. But there are two questions. One: is the bar, as he describes it, set clearly? The second question: is the bar set too low? Our view is that the bar is set clearly and we do not believe the bar is set too low.

He cites two examples in which he states where the bar should be set. In both those cases, that is lower than we would expect, for example, of a consultant who had been practising for a period of time. The bar varies, of course, depending on what that doctor's experience is and what you would expect from that doctor within that practice. I will ask Paul to expand a little on this.

**Paul Philip:** Thank you, Niall. We would say that the bar is set quite clearly in our publication *Good Medical Practice*. Paragraphs 1, 2 and 3 set out, in some detail, the standards that are required of a doctor in relation to the provision of care and the care that a doctor must give. There is a long list of the types of things we would expect doctors to be able to do and the standards to which we would hold them.

I think the real issue Sir Donald raises is: what happens when a doctor falls from grace? What happens when a doctor does not achieve those standards? How far away from those standards does a doctor need to be before it is actionable and, in

particular, before a doctor loses his right to practise and is struck off the medical register? Those three cases are all cases where we clearly asked for the doctor to be struck off and the panel decided it was not appropriate in those particular cases. The issue here is—

**Q4 Chair:** If I may interrupt, that is not quite true, is it? In paragraph 13 of his memorandum he quotes “a panel finding”. The conduct of this doctor, although “falling far below the standard of a registered medical practitioner, is not fundamentally incompatible with continued registration.” That is a panel finding.

**Paul Philip:** Yes. I am sorry. I am obviously not communicating myself properly. We, the General Medical Council, asked for the doctor to be erased from the medical register at the hearing. The panel, which is an independent panel of the GMC, comes to its own conclusions and—you are quite right—it came to the conclusion that it was appropriate not to strike the doctor off in that particular case. In so doing, it has to consider a number of different factors: the evidence that it heard, the facts that it found proven in that particular case and the relevant case law. The relevant case law in relation to this issue has been developed over a number of years and it requires the panel to look at issues such as: is it fundamentally incompatible with remaining on the register? If so, the panel must take decisive action. However, before it does that, it needs to consider issues such as: is the doctor’s conduct or performance remediable? Has it been remediated? Has the doctor made attempts to remediate? Does the doctor have insight into how far away from acceptable practice they have actually been? Importantly, what is the risk of it recurring—that doctor repeating that behaviour—and, therefore, putting patients at risk? Those three particular cases were decided by a panel who heard all the evidence. I am afraid I did not hear all the evidence, but our view was—and I think our view remains—that those doctors should have been struck off the medical register.

**Q5 Chair:** You are seeking to draw a distinction between the people within the GMC who made the case to the panel and arguing that the panel is not, somehow, the GMC. However, in terms of the performance of the professional regulator, it is the panel’s decisions which are of principal concern to us, not the arguments that are made to the panel. That is why I pulled you up. It seems to me that the panel judgment is the judgment, for this purpose, of the GMC.

**Niall Dickson:** We acknowledge that, but it is complex in the sense that—and it is right and people have made it clear—our adjudication process should have a degree of independence from our prosecution function. We are pointing out, first of all, that a lot of Sir Donald’s arguments about the bar are saying the GMC has set the bar at the wrong level. We are saying no, that we do not think we have set the bar at the wrong level. Indeed, in these cases, we pointed to what action we thought should happen.

Panels will disagree with us from time to time. As you know, we are proposing further clarity of

independence by the setting up of a Medical Practitioners Tribunal Service, again within our auspices but distant from us, as it were, and under different controls. But they will disagree. In about 84% of cases panels accept what we are saying. In a minority of cases they do not. In some of those cases, CHRE will appeal on the grounds that it is unduly lenient. As Paul said, we cannot re-try these cases, but our view, as the “prosecutor”, was that these doctors should have been erased from the register.

**Q6 Chair:** I understand that but repeat the point—and then I will invite colleagues to come in because I know they want to—that it is not good enough, is it, for you, as registrar, to distinguish what you sought to argue to a panel from what a panel actually decided? Mr Philip said that one of the constraints is the case law. If a panel is constrained by case law to make a decision which doesn’t stand up—as this one doesn’t, it seems to me, in the logic of its own finding—that is something the GMC collectively has to do something about, isn’t it?

**Niall Dickson:** Indeed. Under the reforms, we are proposing that we would have the right of appeal against panels where we believe the determination by that panel was unduly lenient. In a sense, that is our solution. I am making the point that Sir Donald is arguing something different around our first process, and I think we have good reason to respond to that. Secondly in relation to adjudication, having not been sitting through the whole panel, although we did take a different view, it would require a re-hearing of the case and to understand all the factors in that case to be absolutely sure the panel had got it wrong.

**Q7 Rosie Cooper:** Niall, I am grateful you have come along today, but I have to say that members of the public, listening to this, will be sat there horrified. We have just heard, in what the Chairman read out, a panel finding that a doctor’s practice fell “far below the standard.” The panel accepted it was far below standard and yet it allowed that doctor to continue that practice on various members of the public. People listening to this will be wondering—and I will ask you the question—were members of that panel allowed to sit again? Why did you not appeal? Have you appealed? I am almost bewildered because I cannot understand how anyone can justify it. If there is any doubt about a doctor’s fitness to practise—never mind the legalities and spinning around on the head of a pin—the truth is that that doctor should not be anywhere near members of the public. We hear too much of it.

**Niall Dickson:** I entirely agree. I do not accept that our panels are lenient and are doing this on a daily basis. There are times when, as I have pointed out, we do disagree. I would have to check—I am not sure whether we have the details here—what action the panel did take. As Paul has explained, erasure is one option—removing the doctor from the register. There are other sanctions that they can take against the doctor and I do not know, obviously, in this individual case what sanctions were taken.

I entirely take your point that our purpose is to protect patients. That is the purpose of these procedures and

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14 June 2011 Niall Dickson, Paul Philip and Professor Malcolm Lewis

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that is what both our prosecution function is about and why we called for those doctors to be erased from the register. It is also the duty of panels, as Paul has explained, to look at what the future risk to patients is. A panel that allowed a doctor to go on practising where they presented a risk to patients would be failing in its duty. I entirely accept that.

**Q8 Rosie Cooper:** Would you be so kind as to write to the Committee and tell us what happened in this situation: whether those panel members are still hearing these cases, whether you did appeal in that case and exactly what is going on? People need reassurance that it is not just words but you followed it along right to the point at which that doctor—whoever he or she is—is not carrying on practising and in contact with patients.

**Niall Dickson:** Can I repeat the point that I made to the Chair? We do not have a right of appeal. What we are asking for in our fitness to practise reforms is that we have the right to appeal. At the moment, CHRE have the right of appeal. They look at every single case and they will have looked at this one. I think there is a question about where that bar is and CHRE will take legal advice about whether the court would be likely to accept their appeal. In other words, was what the panel decided that which a reasonable panel could not have reached, which is the bar that Parliament has set for this?

**Q9 Chair:** Whose consent are you seeking for a right of appeal? You said you are seeking a right of appeal.

**Niall Dickson:** We have recently consulted on this matter and asked if we could have that right of appeal. It would then require to come as legislation.

**Q10 Chair:** It requires primary legislation.

**Niall Dickson:** It requires changes to primary legislation from Parliament and we are asking for that.

**Rosie Cooper:** I am grateful for that. With all due respect, the public will think the fact that you are in that situation and that this is going on today is a joke and needs addressing pretty darn quickly.

**Q11 Valerie Vaz:** Can I follow up the tribunal point and ask how far you are down the road on that and if you could explain—it is something that has come out that is confusing me—the difference between erasure and being struck off? There is voluntary erasure, which we will come on to later, but could you explain the differences?

**Paul Philip:** It is fairly straightforward. We use the term “erasure” because that is the term used in the Act. It is exactly the same as the common parlance of being struck off, so if the doctor is erased from the register it means he has been struck off. If a doctor asks to come off the register of his or her own volition, we call that voluntary erasure. I have to say I think the language is misleading. Nevertheless, when a doctor asks to come off and there is no fitness to practise concern at all—obviously, they can come off the register as and when they wish to do so—we call that voluntary erasure.

**Q12 Valerie Vaz:** How far are you down the road on setting up the tribunal?

**Niall Dickson:** Again, we are in the process of consulting on that. The consultation ends at the beginning of June—

**Paul Philip:** It ended yesterday, actually. We have finished three months’ consultation on the future of adjudication at the General Medical Council further to the Government deciding that it is not pressing ahead with the proposals for OHPA—the Office of the Health Professions Adjudicator. We have just finished that consultation, the main components of which were to fundamentally change the governance arrangements of adjudication, to make sure that they are as separate as they can be within the constrictions of the Medical Act and to establish a Medical Practitioners Tribunal which would have an independent head. That would be someone with senior judicial experience who would be able to give leadership to the panels.

One of the real issues we face at the moment is that we present cases to the panel and the panel needs to make its own decisions. Those decisions, clearly, need to be fair in the interests of both patients and the doctor. We are arguing here today about whether or not, in particular cases, we got the balance right. Arguably, in my opinion, we got it wrong. They need to be fair. One of the key aspects is how we performance manage panellists, the people who sit on these cases and make decisions. It is very difficult for us to do that when we are the people bringing the case. It will be much easier in future for a senior judicial person, separate from myself or from Niall, to do the performance management of panellists so that the Council can be assured we are getting the correct performance management of the individuals that make these really important decisions.

**Q13 Valerie Vaz:** Yes. I don’t think you are even compatible with the Human Rights Act or even judicial review grounds, are you? You are judge and jury in your own case. I am interested in what you say about why you are bound by case law.

**Paul Philip:** Everyone is, as I am aware. The fact is—

**Q14 Valerie Vaz:** No. Each case will turn on its own facts.

**Paul Philip:** Absolutely.

**Q15 Valerie Vaz:** You are not a judge and jury, are you, as such, although you operate a quasi judicial function?

**Paul Philip:** We operate a quasi judicial function. The doctors each have—and rightly so—a right of appeal under section 40 of the Medical Act. Doctors are well represented in our proceedings. They regularly litigate against us in relation to appeals. That produces case law. There is a variety of cases that set out the parameters that our panels need to follow—not only our panels, but all health care professional regulatory panels—in making proportionate decisions about doctors.

**Q16 Valerie Vaz:** Sir Donald, in his memorandum—I think you have seen it—mentions benchmarking and

referred to cardiothoracic surgery. Why can't that be rolled out over all the other disciplines?

**Niall Dickson:** We are having discussions with the cardiothoracic surgeons. They are by far, in terms of the profession, the furthest ahead in being able to do that. That reflects two things. One is the enthusiasm of that specialty and the very hard work they have done over a considerable number of years. Secondly, obviously it is easier, in some ways, to measure outcomes in cardiothoracic surgery than it is, for example, in general practice or psychogeriatrics.

The profession as a whole has a lot to learn from what the cardiothoracic surgeons have done. We are having conversations with them at the moment about how they can help us, particularly as we take forward the revalidation proposals. In that sense, we are absolutely in the same place as Sir Donald, but recognising, of course, that we need to get revalidation up and running. We need to get this going and we certainly would not subscribe to a view that you cannot start revalidation until you have, for example, the level of outcome results which cardiothoracic surgeons achieve because, frankly, we would be sitting here in 20 years' time still talking about why we do not have revalidation as a profession. We are very determined to get this thing up and running. It will be a good system when it gets going, but it will not be perfect. Of course, we will be able to develop it in time and one of the things we want to do is look at how the information doctors bring into their appraisals becomes more outcome based as we develop practice.

**Q17 Valerie Vaz:** But, surely, this would help you. You have a set of benchmarks. You know they have done it already. Surely this would help you with revalidation. It is all there, done and ready to run. You say you are keen to do it. What is your time frame?

**Niall Dickson:** We would expect a cardiothoracic surgeon to bring to their appraisals supporting information of a sophistication and on a numerical-style basis that would be much more difficult to achieve, for example, with a general practitioner.

**Professor Lewis:** For the purposes of revalidation, the six items of information that doctors will be expected to bring to their appraisals over a five-year period will be: evidence of annual continuing professional development, CPD, and there will be guidance from each of the specialties in line with that; evidence of analysing and responding to significant events within their practice; some analysis of complaints, and indeed compliments, and how that affects practice; some issues around quality agenda, which might be audit or any other quality improvement methodology implemented in practice, either by an individual or by teams, and the outcome of that. In the context of that item, we are expecting—in fact the Academy and the Colleges are working on this now—the individual Colleges and faculties to produce guidance for doctors working in that specialty pretty much in line with what is available for those specialties. Coming back to Niall's point earlier, different things are available to different specialties in terms of what might be an element of benchmarking or an element of available evidence and that guidance will be used by people in

the different specialties. Finally, there will be colleague questionnaires, 360 feedback from the team, and also patient questionnaires which ensure that, where people see patients, there is an input from patients into the process.

When we last met you to talk about where we were with revalidation, we had not quite come to an agreement with the Academy and the Colleges as to where we should be. We rapidly made progress, subsequent to that meeting, and we have now published a piece of work we did jointly with the Academy and the various College leads on appraisal and revalidation in order to come to where we are. This is now available on our website. The piece that we are awaiting—and I know the Colleges are working very hard on it as we speak—is to put together the specialty-specific guidance for those various domains around, for example, CPD, and in particular around the quality agenda and the sort of thing that you are talking about.

**Q18 Valerie Vaz:** How different is that bar compared to entry to the profession?

**Professor Lewis:** I have to say that the concept of entry to the profession in most specialties is very different to a point that one is at 15 or 20 years later on. The least deviation, I suppose, is in general practice where the curriculum is so broad that it lasts for a career. There is little change in that. There may be added things that people do, but the breadth of general practice people normally still do throughout their career. If, for example, you get on to the specialty register at the GMC as a general surgeon, it is quite likely that, within a few years, you are only going to be doing vascular surgery. If you are doing orthopaedics, you may only be doing hand surgery. Therefore, the bar, or the benchmark, for that sub-specialty is going to be very different to the point of entry to the specialty register as more of a generalist. It is quite difficult to think of a single bar for the whole of the profession.

**Q19 David Tredinnick:** I would like to ask you some questions on a different subject, doctors' relationships with other health care professionals. How does the GMC assess the value of what other regulated health care professionals, such as osteopaths, have to offer and how does the GMC ensure that its registrants—doctors—pass patients on to those practitioners when appropriate, please?

**Niall Dickson:** Our advice on referral is at a high level. We do not say, "You should refer to X," or "You should refer to Y." What we would say is that doctors have to make appropriate referrals to qualified practitioners who are able to add value beyond which the doctors themselves are not able to.

**Q20 David Tredinnick:** Osteopaths have been regulated by Act of Parliament since 1990. Do you have a list of non-doctor practitioners to whom you recommend doctors or not? You leave it to the doctors, do you?

**Paul Philip:** No, we don't. We very much leave it up to the doctors. The doctors, of course, are obliged to carry out their patients' wishes. If the patients were

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interested in accessing that type of help, I am sure doctors would facilitate that. There is an issue about the evidence base, but it is not for the doctor. It is very much for the patient to seek the type of help and support that they want.

**Q21 David Tredinnick:** My second question relates to the first one. If you take the situation at George Eliot Hospital, in the Midlands near my constituency, they have been using aromatherapy for six years to help in the neo- and post-natal clinic, approved by the Chief Executive and supported by the obstetricians, who say that it is enabling them to deal with the really important patients, using forceps, etcetera, and that the stress management has been taken off their back. Do you have a view on whether there is any liability for the doctors in using these other practitioners and making use of their facilities? Is this something that has come up on your radar at all? I am not suggesting, for a second, that there is a problem—I think it is a tremendous development because it is providing very cost-effective therapy, taking the pressure off doctors, and is probably the future—but I wondered if the GMC had considered this.

**Niall Dickson:** Our guidance is pretty clear about what doctors have to do. There are other examples. For example, some years ago the Christie Hospital used aural acupuncture for women who were on tamoxifen, to counter the side effects. The answer is that these interventions, of themselves, are not dangerous. The question is how much good they do and, therefore, the level of risk for a doctor encouraging or being involved in transferring somebody to that as long as the limitations on what is being done are made clear to the patient. It is a question of patient safety, which the doctor must take into account.

**David Tredinnick:** Thank you very much.

**Q22 Andrew George:** I have two areas of questioning. First of all, following on from the new system, on which you have been consulting, if you are saying, as your submission does, that patient protection is the driving force—and we know that medicine is not a precise science—I would like you to comment on how you distinguish between the issue of competence and the fact that medicine is not a precise science. In the area of generalist medicine, when you are trying to diagnose from the spectrum of potential conditions, and particularly in an emergency or urgent situation, how do you balance competence versus the challenges of the profession itself where, clearly, human error and misjudgment inevitably occur?

**Paul Philip:** Do you mean within our fitness to practise procedures?

**Q23 Andrew George:** Yes; for example, in meningitis cases. I am aware of cases where patients have died because of misdiagnosis at an early stage.

**Paul Philip:** Indeed, yes. The caricature is the local doctor who is called out in the middle of night to see a young mum and a very ill child. He or she gives appropriate care to the baby, perhaps, leaves and goes back to bed and does not keep a contemporaneous

note. The baby is brought into A&E two hours later with classic signs of viral meningitis and dies. Question mark: was the doctor at fault? We deal with those types of cases day in and day out. The only way we can deal with that is to look at the standards of care prescribed by the relevant Royal Colleges and get expert opinion as to whether or not, in the specifics of that case, the doctor acted appropriately. That is the only way in which we can do it.

**Q24 Andrew George:** As a result of cases that you take up, do you offer advice to the Royal Colleges with regard to national clinical standards in terms of perhaps addressing issues of a more precautionary approach in certain circumstances?

**Paul Philip:** To be honest, it is usually the other way round. We are an ethical body and we are dealing with doctors' conduct. There are only one or two lines in *Good Medical Practice* which say things like, "You should act within the boundaries of your competence. You should keep up to date and be fit to practise,"—that type of thing. The question that arises is whether or not, in those specific circumstances, the doctor acted reasonably. We work very closely with the Royal Colleges and it is the Royal Colleges that set the clinical standards, as it were. Thus, implicitly, the experts or the performance assessors we use are using Royal College guidance time and time again and we work closely with the Royal Colleges to make sure that they are up to date.

**Niall Dickson:** Moving forward, we are hoping to build on the information and data that we receive, which includes the pattern of our fitness to practise cases, so that we become more of a learning body and are able to reflect those trends back to the profession—more two-way. Paul is right, obviously, that the setting of clinical standards is the job of the Royal College in that technical sense, but we also have a role in reflecting back to the profession, both from our educational experience, because we are responsible for regulating both undergraduate and postgraduate education, and also from our fitness to practise work. We will be doing more of that in the future.

**Q25 Andrew George:** I want to move on to the issue of the increase in referrals, particularly doctors from minority ethnic groups who are overrepresented in your fitness to practise hearings and decisions. We know, in the hospital context, that doctors from the Asian subcontinent, in particular, seem to experience a glass ceiling as far as getting beyond the house-doctor level is concerned. If minority ethnic groups seem to be overrepresented, is that something you, as the GMC, can perhaps better understand and advise on or provide suggested remedies for?

**Niall Dickson:** Perhaps I can give an initial answer and then Paul can give some detail. This is an area which the GMC has been concerned about for quite a number of years. To be clear, as far as we are able to see, the issue appears to be about doctors who are trained overseas rather than doctors of ethnic minorities, though, of course, the two tend to go together. If we look out on doctors from ethnic minorities who are UK trained, that is not on our

radar. The issue of where you are trained seems to be a more important factor.

There are then two questions we have to ask ourselves. First of all, we have no doubt there is a disproportionate number of cases that come to us from doctors who are trained overseas. That could be for a variety of reasons. It could be to do with their training, the degree of support and induction or it could be a prejudice within the health system. There is a whole series of things like that. We have had a dialogue in the past and we continue to speak to groups of BME doctors and others about this issue. In our limited way, we certainly want to look at whether we can provide induction support for doctors when they first come on to our register.

The second issue is about our processes and whether they are fair in relation to doctors coming in. The research we have done thus far indicates that they are fair, but, again—Paul may come on to it—we are going to do more on that.

**Q26 Andrew George:** In terms of the referral itself, some of us might fear that that pattern might have been provoked by a lower tolerance level with regard to BME doctors. I wanted to make sure that that was something of which you were going to be sensitive?

**Paul Philip:** Absolutely. Factually, if you look at our intakes—complaints about doctors—last year we got about 7,100 complaints. If you look across all categories of referrals from patients and the public, from the police and from the NHS, there is no disparity of intakes between white doctors and doctors from BME groups. If you look at referrals from the NHS and from the police, however, there is a marked increase—a disproportionate increase—in doctors from BME groups. Therefore, it does raise the issue: are there white doctors in the NHS who are being treated differently, as it were? Of course, we do not manage and we do not regulate the NHS. However, with revalidation coming on-stream, I am already very keen that the assessments made within revalidation are fair and we are working with a number of bodies to make sure that is the case. We are introducing something called employment liaison advisers. That is, essentially, outreach to the NHS. These individuals will work with responsible officers—medical directors—to make sure that the recommendations made in relation to revalidation are acceptable and fair. We will be looking, as Niall said, at the aggregate data and saying, “Why is it that all the people you haven’t said are okay are orthopaedic surgeons or GPs or are from a particular demographic?” We will be shining a light on this type of thing to make sure that decisions are fair in the future.

**Professor Lewis:** There are bits of subtext to this question. For example, a higher proportion of overseas qualified doctors work in peripatetic locum situations. In moving around within the NHS and not belonging to one organisation, the threshold for referral might be lower because there is no local governance around that doctor when they move on. I do not have any facts on this in terms of the reality of the figures, but it is something that, anecdotally, stands out and we do need to look at.

**Q27 Mr Sharma:** As to overseas qualified doctors and the BME doctors qualified here, do you have any figures—what is the percentage—which say you have more qualified doctors from overseas that come into this category than the ones from here?

**Niall Dickson:** Yes. I can give you the detailed figures. We will send them to you afterwards. As far as BME UK-qualified doctors are concerned, they do not appear in our procedures any more than you would expect by the proportions. There can be reasons for that. The kind of person who comes to our fitness to practise procedures tends to be older and male, so there are other characteristics which, again, make this quite a complicated subject. As I say, at the moment we cannot see—and of course there are increasing numbers of BME UK-qualified doctors who are coming into the system—any evidence of them appearing disproportionately in our procedures.

**Chair:** Sarah wants to come in on overseas-trained doctors and some of the issues on that. It is timely to do so.

**Q28 Dr Wollaston:** There were two issues I wanted to raise. One was the issue of how far the GMC feels it has adequate powers to monitor underperforming doctors from other regulatory bodies overseas, both within Europe and further afield. I know we are going to touch on the issue later about voluntary erasure, but there is a concern that sometimes people who accept voluntary registration perhaps will practise somewhere else like Australia and therefore the Australian authorities are unaware there was a problem with their practice.

**Niall Dickson:** We are one of the most open regulators in the world. We not only publish—which, again, is not true in lots of parts of the world—the names of all the doctors on our register, but we also publish any fitness to practise issues about them. We send out a bulletin to every regulator in the world detailing any actions which we have taken against doctors. Therefore, the Australian regulator should know about it.

**Q29 Dr Wollaston:** In which particular countries do you see an issue with their regulatory bodies? Do you think there should be extra procedures put in place to make sure we are not accepting doctors from countries where there is inadequate regulation or publication of data?

**Niall Dickson:** The European Union is slightly different but, outside the European Union, we recognise certain medical qualifications. On top of that, we require those doctors to demonstrate their language competence. Then they have to go through both a written clinical exam and a practical exam in order to get on to our register. Therefore, we are reasonably confident that that, in itself, is a robust process.

As far as Europe is concerned—and I have said this before to this Committee—obviously we have concerns. A lot of concentration has been on language as the issue but we have concerns because we have no means of checking the competence of doctors who are coming from the European Union, as the arrangements stand at the moment. If those doctors

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have a certificate of good standing from a competent authority within the European Union, we have to admit them.

**Q30 Dr Wollaston:** Thank you for that. That brings me to my next point—and last time we met we did talk about this issue—which is: how much further on are you in your discussions both with the Government and European countries about this issue?

**Niall Dickson:** I am pleased to say that I think we have made very good progress. As everybody is aware, it is a complex and difficult area. With colleagues from the DH, we are at the final stage of finalising a scheme which would provide much better safeguards, both in terms of language and, indeed, in terms of competence, than the current arrangements allow. The matter is now with the Department of Health. It is up to Ministers to decide to announce these things, not me, but we have made very considerable progress. Without going into all the detail of the scheme, which again the Department will, I hope—sooner rather than later—get into the public domain, first of all, it would require a change in the UK Medical Act.

Secondly, that would enable us to apply at the first stage, when the doctor applies to come to this country. If we had a doubt, which is what is in the European legislation, we would be able to ask for language competency. Once they got through that stage, there would be a process of involving the responsible officer.

Under the new legislation, responsible officers who are at employer level but have a link back to the GMC have statutory responsibilities for ensuring that the doctors they employ are competent and fit to practise. The scheme would have a link back so that, when somebody first comes on who is new to the register, they engage with the responsible officer. They would then have a link back to the GMC where the responsible officer would sign off that that doctor was competent and fit to practise. We think we have made considerable progress. Some of the detail is still being thought through, but we believe it is compliant with European law, and that, if we can get UK law changed, it will be compliant with UK law as well.

**Q31 Dr Wollaston:** Thank you. Can I pick up on a point you made earlier? You said that doctors from outside the European Economic Area have to sit both a language and a medical test of their competence. If that is the case, is that bar set too low given that so many of them appeared subsequently at your fitness to practise hearings?

**Chair:** If I may, to reinforce that, you started off this passage by saying that the GMC has concerns about doctors from these backgrounds.

**Niall Dickson:** Yes. Let me be absolutely clear. The NHS could not have survived over the last 20 or 30 years without really good practice by very large numbers of doctors who have come from overseas.

**Dr Wollaston:** That is not in question.

**Niall Dickson:** I was questioning more the service, and indeed maybe us in the past: have we done enough to support these doctors when they first come to this country? As far as the current tests are

concerned, we are confident that they are valid. We have recently launched a review of them. We have to do that and it is right to look again, fundamentally, at how what is called the PLAB test works and how effective it is. One of the points to be clear about, going back to the bar question, is that the PLAB test says you have to be the equivalent of having finished your first year of foundation. That is the most junior kind of doctor possible, because that is the entry point to the register. That is where the PLAB test is set. It is important that employers in other scenarios for the future absolutely recognise that having somebody on the register does not mean they can do everything that any doctor can do. It is set at a particular level. Therefore, we are looking at that test again, and it is right that we should do so, but we have no reason to believe that it is not correct.

There are issues about doctors moving around from one country to another. There is the assumption that, if you are trained as a doctor, you can do it. I think medicine is culturally and institutionally specific. To be fair, the PLAB test—having watched it in action—does test out some of those cultural issues, but people who have moved from one country to another, unfamiliar with our systems and with our culture, absolutely need proper support. That needs to be provided at employer level, but there may be something we can do as well on a basic induction level for people who are starting out.

**Q32 Dr Wollaston:** You think it is about induction and support rather than a problem with the PLAB test itself.

**Niall Dickson:** I have no evidence that there is anything wrong with the PLAB test, though we have ordered a review of it because it is eight years since we did so. It has a group of expert educationalists and doctors who monitor it all the time and check that it is valid and all the rest of it, but having a fundamental review of it is the right thing to do.

**Dr Wollaston:** Thank you.

**Q33 Valerie Vaz:** Is it written or is it online and how many times can they take it?

**Niall Dickson:** That is one of the questions which we have asked the review to look at because, at the moment, they can sit it as many times as they want. There are two things. First of all, there is a written test they have to do—Part 1—which tests their clinical knowledge and skills. Then there is a practical test, which is called an OSCE. They are given 16 stations and they walk in and in front of them is a patient, who is an actor or actress, and a senior doctor who is watching them in action. It gives them a little scenario, outside the door, as to what they are about to see and then they go in and do it. They are marked on each of those 16 stations so we see, in practical terms, what they are able to do. Again, that is, educationally, a valid tool, measuring what it is meant to measure.

**Q34 Valerie Vaz:** Quickly, as a follow-up, in the case of Dr Ubani, where the locum cover is outsourced, would he have to take a test?

**Niall Dickson:** No. He came from the European Union and the European Union diverts right round that test.

**Q35 Valerie Vaz:** What concerns do you have that you capture those sorts of—

**Niall Dickson:** As I explained to Sarah Wollaston, the scheme, as we are doing it, does not impose all those things on European doctors. That would be contrary to European legislation. What it will do, though, is this. When the doctor gets on to our register, because of what Parliament has already done by creating responsible officers—and we might even tighten up the regulations around this—when they first come and apply for a job, it is not only somebody in a hospital saying, “It’s 10 o’clock at night. Let’s have them on to do this particular job.” The responsible officer, or somebody he delegates to, will have to sign off that they are taking responsibility for saying that doctor is competent to do the job they are doing. It is a further tightening of that process. If that had applied in Ubani’s case, I very much hope the responsible officer there would have said, “I have significant doubts about this.” I am not saying it is perfect.

**Q36 Chair:** Can I ask you a question going back to the discussion we started out with on fitness to practise and how that feeds over into revalidation but asking you, this time, a question in your role as the prosecutor arm, if you like, of the GMC? It relates to a doctor’s professional responsibility to have an interest in the practice going on around them by other doctors and other clinicians. Is that a theme you follow up in the actions of doctors whose individual practice with their patients may be blameless but where they may have questions to answer about what was going on around them, about which they should have been aware and about which you received no report?

**Niall Dickson:** Yes, and it is an area that still causes us concern. I do not want to deny there has been progress. If I look back over the years—long before I came into the GMC—there has been significant advance within the culture of the medical profession. People are much more likely now to raise issues about colleagues than they were 15 or 20 years ago. I also recognise there is a lot more to do. Our guidance is absolutely clear on this matter and reflects, in a way, what Dame Janet Smith said, which is that one of the best forms of patient safety is colleagues keeping an eye on other colleagues. All our guidance is very strongly orientated towards that.

As far as fitness to practise cases are concerned—again, Paul may wish to comment on this—we have had examples, not huge numbers but examples, where doctors who are managers have failed to take action, as it were, and have been brought before us for their management responsibilities allied to their medical responsibilities. I suspect the answer is that this is not about the GMC hauling up individuals in particular cases so much as trying, or continuing to change the culture within the profession. We will take action if we believe that doctors have put patient safety at risk and have not taken action, even if it is not about their own individual practice.

**Q37 Chair:** Can I apply that principle to a very specific current case, Winterbourne View? There must have been doctors who went into that home. It seems to me that it would, at the very least, send a powerful message into the system if any doctor who was in that home during, say, the six months before that programme was made, was felt by you, as the prosecutor—not finding them guilty of anything—had questions to answer.

**Niall Dickson:** Indeed, we have questions. I am not going to comment in detail on ongoing cases—and Paul can give you specifics—other than to say that, clearly, we are interested in any doctor who had contact with that hospital or home. We are interested in what contact they had, whether they had opportunities to see what was going on and any action they took or, indeed, what responsibilities they had. We do have ongoing action on that. I do not know if Paul wants to comment on who we have spoken to.

**Paul Philip:** Yes, to say, absolutely, I very much agree with you. It is a fundamental issue. We provide guidance for doctors in management and *Good Medical Practice* sets out clearly that, where doctors see substandard practice, they have a professional obligation to act. There must have been doctors in the vicinity and we are in discussion with Castlebeck—the company that runs the home—with the CQC—the local safeguarding board—and the police to make sure that we identify those doctors. So far we certainly have a number of names and we will be following those up.

**Q38 Chair:** What sanctions are open to you if you find a doctor that you think should have reported something that he or she did not report?

**Paul Philip:** The full panoply of sanctions is open to us, depending on how seriously the matter is viewed in the context of the actions or inactions of the doctor.

**Q39 Chair:** When did the GMC last sanction a doctor on these grounds?

**Paul Philip:** Again, it depends what the misdemeanour—if I can call it that—is. If it is a failure to act in a managerial capacity, for instance, “Were there doctors in management in this organisation?”, then the most high profile one was Bristol, 10 years ago. We have acted in relation to two or three, even in Niall’s time, over the last two years and we have a number ongoing at the moment in relation to other high profile NHS failings.

**Q40 Valerie Vaz:** Was there a referral or were you proactive in looking for the doctors who did not act in an appropriate way?

**Paul Philip:** Mainly they are brought to our attention through the normal means, so if there is a high profile media issue that appears in the papers we will follow that up and check. That is usually how failings in management come to our attention.

**Q41 Chair:** It is part of the culture change that Niall was talking about, is it not—

**Paul Philip:** Yes, it is.

**Chair:** —that it is understood that a doctor whose individual practice may be completely blameless is

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open to criticism, and public criticism, if this goes on around them and they do not report it?

**Niall Dickson:** It is not just other doctors. It is anything they see where patient safety is at risk. That is an absolutely prime duty.

**Paul Philip:** There has been a finding of nearly every public inquiry in relation to failings of doctors over the past 10 years, so absolutely.

**Chair:** Thank you.

**Q42 Mr Sharma:** Following on from Sarah's question, you said there are no changes in the standards, that they are still the same standards now as previously. Why do you think that greater numbers of old male doctors from the BME appear in these cases than the young ones if standards have not changed?

**Niall Dickson:** This is nothing to do with Winterbourne, is it, to be absolutely clear?

**Q43 Mr Sharma:** No. I am sorry. I said I am taking it back.

**Niall Dickson:** Going back to that issue, I could only speculate. The answer is, of course, that quite a lot of doctors who are coming up to retiral now were let in under very different regimes. Again, I would be very hesitant to apportion any blame to those individual practitioners. I do not think the NHS has a fantastic record of supporting doctors who have come from overseas, many of whom were expected to work in the poorest areas of the country without proper support and so forth. I am not saying that is the reason, but I think the history is different from where we are at now.

**Q44 Rosie Cooper:** I have two questions. I would like to return to voluntary erasure. Your guidance states that voluntary erasure should be granted only where it is in the public interest, in the interests of the complainant or the private interests of the doctor. Which of those do you think takes precedence?

**Paul Philip:** The public interest.

**Rosie Cooper:** The public interest?

**Paul Philip:** Yes.

**Q45 Rosie Cooper:** In that case, how would you justify—and, almost, to what extent did you ignore—your own guidance in the case of Owen Gilmore when, despite very serious allegations, he was allowed to erase his name voluntarily? I would put it to you that there is every danger the GMC could be accused of being fair to the doctor ahead of everything else, and especially when you can often give very short notice of the fact that an erasure hearing is going to take place. In our documents, it is clear that three hours has been the amount of notice given on occasion. I don't understand how that can be seen to be in the public interest and/or have the perception of fairness.

**Paul Philip:** I am afraid I am not up on the facts of the case. However, where we refer a doctor to a fitness to practise hearing—and I think it was a fitness to practise hearing that gave the doctor in question voluntary erasure—we advertise that hearing usually 28 days beforehand and it is on our website that,

within 28 days, that will be a public hearing. Again, I do not know the details of the case but we should, and our normal practice is to publicise that.

The panel in question can hear representations of all sorts from both parties. Presumably, an application was made by the doctor's lawyers for voluntary erasure. The panel would have gone into private, discussed what to do and would have considered our guidance. Where it gives voluntary erasure, it is obliged to give adequate and appropriate reasons for so doing. Again, perhaps I could come back to you on the specifics of the case because I am not familiar with them.

**Q46 Rosie Cooper:** The three hour case is, in fact, the doctor facing 19 charges of fraud who avoided prosecution by claiming to be permanently unfit for trial. He recovered and went to work in Australia. When a GMC hearing was scheduled in 2010, he stated he was not fit to participate. The insurer was initially given three hours' notice of a voluntary erasure application and appealed. He got an extension, but the GMC still allowed his erasure. How do the public get any confidence from processes like that?

**Paul Philip:** Again, I would need to look at the details of the case. From our perspective, the question is: is the doctor a danger to the public? Removing them from the register is the ultimate sanction that we have. When they can no longer practise as a doctor, they can no longer do any harm as a doctor in the doctor-patient relationship. In circumstances where a doctor comes off the register and there were concerns, it is important that we tell other regulators what the issues were, absolutely, and Niall has already said that we do that.

However, there are circumstances where it is better to take the doctor off the register rather than face a hearing where it is likely that he will not be taken off the register, to go back to where we began this discussion an hour ago. The public is absolutely protected when we take a doctor off the register. What is important, however, is that they do not become an applicant at a future date and, therefore, are allowed to escape some form of justice and slip back on to the register. In our consultation document on this, which has just concluded, we have suggested a whole load of safeguards for making sure that that does not happen in the future.

**Q47 Chair:** If a doctor is subject to very serious charges and applies for voluntary erasure before those charges are established, isn't the question whether those charges are then reported into regulatory regimes elsewhere because, as far as you are concerned, they are charges rather than proven offences?

**Paul Philip:** That is correct. At the moment, we do tell other regulators the concerns about the doctor but we do not put into the public domain those concerns in the UK. We want to change that so that, in future, where a doctor agrees a sanction that the GMC thinks is appropriate, such as removing their name from the register, we publish the concerns that were extant at the time.

**Q48 Valerie Vaz:** Presumably that does not become part of your case law in the case of voluntary erasure?

**Paul Philip:** No, it would not become part of case law unless it was subject to litigation.

**Q49 Rosie Cooper:** But, of course, allowing that means that the complainant never gets a hearing, never gets to put the case, never gets closure, almost.

**Paul Philip:** Yes. It goes back to the purpose of our fitness to practise procedures. We say that the purpose is to protect the public, not to provide some form of redress for patients. That is not to underplay the importance, as you say, of closure—it is a fine balancing act—but we think that where the doctor agrees to take an outcome which would fundamentally protect future patients, we should take that as long as there is a public audit trail of what the concerns were.

**Q50 Chair:** Can we be very clear about this? I think I am hearing you to say that if a doctor is subject to a fitness to practise procedure and then applies for voluntary erasure, you will agree to voluntary erasure but you will publish the facts that are the subject of the fitness to practise process.

**Paul Philip:** That is the proposal we have just consulted on. We have just finished that consultation and that is what we would like to do. In order to be able to do that, in serious cases, it will need legislative change and we are now entering into discussions with the Department of Health about whether or not we can bring forward those changes. But, yes, we would like to change the nomenclature because we think “voluntary erasure” does not quite hit the button, as it were.

**Q51 Chair:** It amounts to a guilty plea.

**Paul Philip:** Indeed. It is essentially accepting it—

**Niall Dickson:** It is a doctor agreeing to what we are saying.

**Paul Philip:**—and us then putting it in the public domain.

**Q52 Dr Wollaston:** At the moment you publish the fact, and it is available worldwide, that they have accepted voluntary erasure but you cannot publish the reasons for that happening. You would like to be able to do so in the future.

**Paul Philip:** That is correct, although we do tell other regulators where we know that the doctor is leaving the country. If the doctor were going to another country, we would tell the regulator that the doctor has taken voluntary erasure in the very specific circumstances we have decided to agree to that when there were still concerns about his practice.

**Q53 Mr Sharma:** How do you find out they are leaving the country to go to another country?

**Paul Philip:** It usually comes out in the case. When they make the application, they will say what they intend to do in the future.

**Chair:** Yvonne, you have been more patient than is reasonable. I apologise.

**Q54 Yvonne Fovargue:** You mentioned before that you share the fitness to practise hearings with other

medical professionals. I would say the public are one of the major stakeholders in this and one of the major concerns, certainly, in any cases that lead to voluntary erasure. How do you publish cases and do you publish cases, in fact—regular analyses of cases—that show your bar, show where it has not been reached and show the results, whether the doctors took voluntary erasure or did not? Do you publicise that to anyone?

**Niall Dickson:** We publish fitness to practise statistics, and some limited analysis of that, which are presented to Parliament every year. This year we are extending that to include a greater degree of analysis of what these figures mean. We will build on that as we go forward.

At the moment, our systems have broadly been set up to deal with cases: the doctor comes in, we deal with it and the doctor leaves. There isn't learning within the system. We are attempting to build around that system so we start to understand more about the sorts of cases that are coming forward and where those cases are happening; for example, what is happening in one region versus another or what is happening within one institution. If, for example, we had lots of referrals from a particular institution—as Paul says, when we have employment liaison advisers we will have a better feel anyway—and, also, if that was an outlier we would certainly want to raise a question. It may say that the quality of medical practice within that institution is not good or it may indicate that the clinical governance is very good because they are spotting things that are going wrong. We need to have more of a learning environment where we are spotting trends and we are reflecting that back to the profession and demonstrating what we do. But we do publish, at the moment, what actions we take in the way that you have described.

**Q55 Yvonne Fovargue:** Demonstrating to the public as well, not just to the professionals.

**Niall Dickson:** Indeed. We are doing a lot more now in engaging with the public, in terms of individual patient groups. One of the other things that we are doing this year is setting up regional liaison advisers throughout England. We do better in Scotland, Wales and Northern Ireland where we already have offices and, therefore, quite close contacts with patient groups and others. England has been a bit of a black hole and, by setting these up, we will have a much better feel at local level, where there are local patient groups who may have concerns about particular aspects going on, so that we are not simply a remote regulator but we are having ongoing dialogue with them.

**Chair:** Thank you. I have a whole series of quick questions, including one I want myself.

**Q56 Mr Sharma:** It is a brief but strange question. When somebody accepts or offers to take voluntary erasure, do you inform the local surgery and the other local doctors? That is the first question. Secondly, if you are not informing them, if there is no display that this doctor is no longer in this service, or not supposed to do it, but they have a practice—a husband and wife or brothers are jointly holding it—it is the case that that male old member can still go and quietly provide that service. If that is the case, how do you find out?

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*Niall Dickson:* If anybody is quietly providing medical practice, that is—

**Q57 Mr Sharma:** If there is no display.

*Niall Dickson:* It is against the law. If they are not on the medical register, it is a criminal act to start practising medicine. I will get Paul to give some of the detail. I would add a very broad point. On most voluntary erasures, doctors are simply giving up and retiring and we ask them a whole series of questions, mainly, do they have anything we do not know about in their history which might raise questions as to whether they should be given voluntary erasure. We have that process.

*Paul Philip:* Last year there were 2,898 applications for voluntary erasure. With the vast majority of those, there was no concern whatsoever in relation to the doctor. They were simply leaving the register. We do not tell the partners of the employers of doctors. We put it on the register. It is clearly a criminal offence if they were to act as a licensed medical practitioner when they are not on the register. That is the position as it stands.

**Q58 Rosie Cooper:** I suppose the proof of the pudding is in the eating, almost. I have a great deal of respect for the General Medical Council, as you know, and I believe you are there doing a grand job, so my next question is a bit double-ended in the sense that I wonder what involvement the GMC have had in the Mid Staffordshire Inquiry. What did you do? What action did you take? Did you find fault? How is practice in that hospital better because of what you did?

*Niall Dickson:* I have to appear in front of the Inquiry on 23 June when I will be providing evidence to the Inquiry of the actions that we have taken and I have provided—and I think it is on the website of the Inquiry—a statement of the GMC's involvement at various levels. They will undoubtedly be questioning me for six hours on this subject, so if I skip across the top of the surface I hope you will understand.

If you ask me what the bit is, at the end of all this—and I am sure they will go into lots of detail—that worries me, it goes back to what the Chairman raised right at the beginning of our discussion, about culture. The fact is that at Mid Staffordshire anything between 120 and 150 doctors at any one time must have seen something that they should have blown the whistle about. There were people who did blow the whistle and there were doctors who took action absolutely appropriately, did the right things and followed our guidance, but it is clear that large numbers of doctors did not. Accepting the point that Mid Staffordshire is a big place and there were things that were undoubtedly very bad, presumably there were other bits that were very good. It does depend on what they were able to see, but it does worry me that the culture change I talked about hasn't meant that doctors, in particular, for whom we are responsible, were not more firmly and earlier blowing whistles about standards of care.

**Q59 Rosie Cooper:** Did you identify any doctors? At the end of this, how is Mid Staffordshire better because of what you did?

*Niall Dickson:* First of all, we have a number of ongoing cases in relation to individual doctors, and I obviously will not comment on the detail of that. There were—

**Q60 Chair:** I am sorry to interrupt. Does that include doctors whose individual practice was blameless but who should have reported what they saw?

*Niall Dickson:* It does. There are a number of doctors in that category.

I have lost my train of thought, but the point is that we have educational responsibilities. We are interested in doctors in training, what they were doing in Mid Staffordshire, how they were supported during this period and what they saw, and there were also medical students at the hospital. There are various areas where we are obviously looking at what we did at that time, although we didn't have responsibility for postgraduate education, which, of course, is the critical one.

**Q61 Rosie Cooper:** I have a quick question to end on the Inquiry. You say you have ongoing investigations. How long will they go on for? When can people see an end to that and see that you have made a difference at Mid Staffordshire? When will the general medical population know that you are serious?

*Niall Dickson:* I have two points. One is that fitness to practise cases are very important but they are only part of demonstrating that we can deal with the Mid Staffordshire problem. However, that is important. Secondly, we take immediate action if we think that any doctor is a risk to patients. We will put them before an interim orders panel within three weeks of being notified and take appropriate action to fetter their registration, put conditions on their practice or stop them practising.

**Q62 Rosie Cooper:** Did you do that at Mid Staffordshire at any time?

*Niall Dickson:* I will not comment on individual cases, but we have done that in relation to cases at Mid Staffordshire. We will take action where this is brought to our attention.

The third thing is that you ask, "How long?" Length is a real issue for us. As to our figures, last year we hit our performance target of 90% of cases done within 15 months. I still think that is too long and that there are cases going too long, which is why our fitness to practise reforms are designed to speed up this process. In relation to the Mid Staffordshire cases, we have put them on hold pending the outcome of the Inquiry—again, not affecting patient safety—we will take action there—but concluding the cases. We think it is appropriate to wait until whenever the Inquiry is concluded because there have been things about individual practitioners that have emerged during the evidence.

**Q63 Rosie Cooper:** I will stop now, but can I say to you that, while you need to be careful to ensure that justice is done—I accept that—the public will get

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greater confidence in what you do and in the hospitals if they could see cause, responsibility and sanction dealt with a lot more quickly? They would then feel far more confident. This goes on and on for a long time and it all dissipates.

**Niall Dickson:** As I have explained, speed is one of the key reasons why we are pushing for reform. I think we have done well. We have had a huge increase in the number of cases, we have diverted resources and Paul has put extra staff in place to maintain the speed with which we are doing things. The reason why cases go on for a long time is extraordinarily complex, not least because it is a legal process, but we are doing everything we can to try and speed that up. If these reforms that we are proposing go forward, it will mean speedier cases, which I think is in the interests both of patients and indeed of the doctors concerned.

**Q64 David Tredinnick:** At a time of financial constraints in all Government departments, are you experiencing any difficulties? You have told us that you are taking on extra staff and, earlier on, you said you were setting up regional advisers. Where is the money coming from? Are you expanding as an organisation or are you following the trend of trying to be more careful where money is spent?

**Niall Dickson:** We are attempting to re-craft the organisation, if I can put it that way. We have taken a number of steps to try and keep the pressure on the fee that we charge doctors. This year we froze the fee that we charge doctors, reduced the fees for those who are going into specialist practice and extended the number of doctors on lower incomes who would get a discount. We hope we can maintain that. That is on the income side.

On the spending side, we have a programme of efficiencies which we are pushing forward. We have saved considerable sums of money by pulling a lot of our legal work in-house. At the moment, we are consulting on proposals to transfer staff to Manchester and we have a whole series of other measures. Paul, since the beginning of last year when I came, chairs a performance board which looks at every aspect of our business. We are a monopoly and we do have an income stream. It is therefore incumbent upon us constantly to look at every area of our business and make sure that we are providing value for money at every stage. We are very conscious of that. We believe we are in a reasonable financial state, to answer your question, but there are variables ahead which are difficult and imponderable.

First of all, fitness to practise is likely an A&E department because you do not know how many cases you will have, and we have seen increases of more than 20% in the last year.

Secondly, as to the number of doctors on the register, again we have been surprised. To the extent that you can predict this, we thought it might tail off. Actually, the numbers of doctors on the register has continued to go up, which, of course, increases our income. Equally, it could go down again.

Thirdly, revalidation is an imponderable because there may be doctors who decide, "I don't want to go through this. I am going to retire," and give up practice. There are all those things and, inevitably, like everybody else, we can only see so far ahead but we think we are in reasonable financial shape.

**Q65 Chair:** I have one brief question at the end. You have said to us, today, there are two specific amendments to primary legislation that you are seeking—both of them very important to the themes that we have been discussing today—voluntary erasure and right to appeal against panel decisions. Are there any other amendments to primary legislation which you think are important to the effective operation of the GMC? If you want to write to us—

**Niall Dickson:** I have a small shopping list that I can provide.

**Q66 Chair:** The Committee would be interested to know because there are few more important priorities in health care than the effective regulation of the medical profession. If you are unable to do your job because primary legislation does not give you the space you need, the Committee would like to know.

**Niall Dickson:** To be fair to the Department of Health, my understanding is that—

**Rosie Cooper:** They have been a bit busy.

**Niall Dickson:**—at least in relation to the European scheme, there is a provisional booking in the back of their heads for something which I think the Committee, us and everybody else would be very keen to see come into reality.

**Chair:** I repeat the request, please, for a brief communication of where you feel your present operation is not as effective as you would like it to be and could be made more effective by a change in primary legislation. Thank you very much.

# Written evidence

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## Written evidence from the Department of Health (GMC 01)

### INTRODUCTION

1. This memorandum has been prepared by the Department of Health in England in response to the Commons Health Select Committee's call for evidence to assist it in exercising on behalf of Parliament the power held by the Privy Council to hold the health professional regulatory bodies to account. The first such session is to consider the performance of the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). The Department is grateful for the opportunity to contribute to this process, and looks forward to contributing to similar work relating to the other health professional regulatory bodies in due course, should the Committee wish.

### BACKGROUND

#### *Accountability of the Health professional regulatory bodies to Parliament*

2. The health professional regulatory bodies<sup>1</sup> are accountable to Parliament through the Privy Council. Provisions in their enabling legislation (the Medical Act 1983 and the Nursing and Midwifery Order 2001 in the case of the GMC and NMC respectively), require the regulators to report to the Privy Council on a number of matters relating to their performance. These include financial performance, how they comply with their duties as a public body in terms of equality and diversity matters, and strategic planning for future years. This material should be submitted to the Privy Council and laid before Parliament.

3. The Department has an interest in this process because, firstly, it acts as advisor to the Privy Council on policy and legal matters arising from the activities of the health professional regulatory bodies and, secondly, has a legitimate interest in the regulators' performance from the perspective of public safety and protection.

#### *CHRE annual performance review*

4. The Council for Healthcare Regulatory Excellence (CHRE) conducts an annual review of the performance of all of the health professional regulatory bodies, including the GMC and NMC. This report, submitted to the Privy Council and laid before Parliament, also ensures that the activities of the GMC, NMC and the other regulators are subject to scrutiny.

5. The CHRE performance review is an annual check on how effective the health regulatory bodies have been in discharging their statutory duties. It has two important purposes which are relevant in the context of the work of this Health Select Committee:

- It drives improvements in the work of the regulators (through CHRE's identification of their strengths, weaknesses, and recommendations as to changes in processes which are needed); and,
- It provides assurance to Parliament, the public, health professionals, and the wider regulatory community about the regulators' performance.

6. The latest CHRE Performance Review for 09–10 was published in July 2010<sup>2</sup>, with the next report due for publication in the forthcoming weeks. The Performance Review considers the performance of the health professional regulatory bodies in relation to their core statutory duties, being:

- setting standards of education and training for the professions that they regulate;
- maintaining a register of those who demonstrate they meet these standards;
- setting standards of conduct, ethics and competence required to remain on the register; and,
- investigating concerns about professionals who are registered and taking appropriate action where individuals might present a risk to the public.

#### *CHRE annual audit of initial stages of Fitness to Practise procedures*

7. For the past two years CHRE have also conducted a yearly audit of the initial stages of the health professional regulatory bodies' fitness to practise processes, looking at a sample of the decisions made by each regulator to close a case without referral to a formal hearing in front of a fitness to practise panel. CHRE do this to ensure that the regulators' fitness to practise decisions protect the public and maintain public confidence. Fitness to practise procedures are key public protection safeguards, hence the importance of this audit in terms of public confidence in this key area. The latest audit was published in March 2011<sup>3</sup>.

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<sup>1</sup> General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOSC), General Pharmaceutical Council (GPhC), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI),

<sup>2</sup> See: <https://www.chre.org.uk/satellite/311/>

<sup>3</sup> See: <https://www.chre.org.uk/satellite/387/>

*CHRE review of all final Fitness to Practise decisions*

8. CHRE also review all final decisions made by health professional regulatory body fitness to practise panels. CHRE have statutory powers under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 to refer to the higher courts any such decisions that they consider to be “unduly lenient” or where a decision should not have been made and so it would be desirable for the protection of the public for such an appeal to be brought. As a general trend, the number of fitness to practise cases being dealt with by the health professional regulatory bodies has risen steadily over the past few years. However, the number of cases where CHRE have had to utilise their Section 29 powers has fallen. This could indicate that the feedback on performance that CHRE provides to the health professional regulatory bodies is contributing to an improvement in quality of decision making across the sector. Legal changes, such as the move to the civil standard of proof in fitness to practise cases, have certainly had an affect. In addition, high courts jurisprudence is also likely to have had an influence in this area—with its guidance on the necessity for giving reasons for decisions, interpreting what is meant by misconduct/deficient performance, and guidance on how impairment should be assessed all making a contribution in assisting in improved decision making in the sector.

*Wider Regulatory Reform*

9. In February 2011 the Government published a Command Paper detailing its strategy for professional regulation: *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*.<sup>4</sup>

10. In *Enabling Excellence* the Government signalled its intention to engage the Law Commission<sup>5</sup> to conduct a review of how the current complex legislative system which governs the operation of the health professional regulatory bodies is arranged, with a view to them making recommendations (and developing a draft Bill for consultation) on how this might be simplified. The Government welcomes the willingness of the health professional regulatory bodies (including the GMC and NMC) to contribute to this process.

11. It is the Government’s intention, through the Law Commission work, to explore the possible benefits of seeking Parliament’s agreement to a single Act of Parliament to create an enabling framework for all the health professional regulatory bodies. Parliament would continue to set out in law a high level framework of powers and duties for the regulators, but as independent bodies they would be empowered to decide on, and take responsibility for, how regulatory outcomes would be delivered in practice. However, greater autonomy must be balanced against strengthened accountability. To this end the decision of the Health Select Committee to scrutinise the performance of the health regulatory bodies is strongly welcomed by the Department.

12. In line with the wider Government policy to reduce regulatory burdens, *Enabling Excellence* also challenges the health professional regulatory bodies to consider in what ways they might reduce costs of regulation in the sector, which are borne by registrant health professionals. The Department has commissioned CHRE to lead research on how this is achieved and we look forward to working with CHRE and the health professional regulatory bodies on these issues in due course.

13. *Enabling Excellence* also sets out the Government’s approach to unregulated parts of the Health and Social Care Workforce, including development of a system of assured voluntary registration<sup>6</sup>.

PERFORMANCE OF THE GMC

*CHRE 09–10 Performance Review*

14. CHRE’s main conclusions as to the performance of the GMC were that:

“The GMC has continued to perform well, demonstrating excellence in several areas across its functions in a year of significant change. It is impressive that the GMC has maintained its commitment to continuous improvement, even in areas where it was already performing to a good standard, and to addressing challenges in medical regulation.”

15. In relation to its core statutory functions CHRE found that the GMC:

- continued to demonstrate excellence through its focus on improving its registration processes;
- reviewed its fitness to practise procedures and changed its rules, which CHRE considered “should ensure that the fitness to practise process is focused on appropriate cases and that the GMC is able to make decisions which are in the interests of public protection”;
- in terms of education and training published standards and outcomes for undergraduate medical education which CHRE considered to be “clear, comprehensive, focused on patient safety”; and,
- coped well with the change associated with the merger of the functions of the Postgraduate Medical Education and Training Board (PMETB) into the GMC.

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<sup>4</sup> See: [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_124374.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124374.pdf)

<sup>5</sup> See Chapter 3 of *Enabling Excellence*

<sup>6</sup> See Chapter 4 of *Enabling Excellence*

*CHRE findings in relation to the GMC in their March 2011 fitness to practise audit*

16. CHRE's audit concluded that the GMC maintained:

“a well managed system of casework with no evidence of significant risks to patients or to the maintenance of public confidence in the system of regulation and the profession.”

17. CHRE did isolate a small number of cases where they had minor concerns as to the action the GMC took. However, after discussing these cases with the GMC, CHRE noted that they were pleased that the GMC addressed these “*few issues of slight concern*”.

*Revalidation*

18. The House of Commons Health Committee published “Revalidation of Doctors”: Fourth Report of Session 2010–11 on the 8<sup>th</sup> of February 2011 (HC 557). The Government published its response in March 2011 (Cm 8028) in the form of a Command Paper. Progress on the Committee's recommendations since March is outlined below.

19. The England Revalidation Delivery Board has agreed clear milestones for moving towards organisational readiness that will allow the Board to assure itself and the GMC that progress is on track for the Secretary of State's assessment of readiness in 2012. Health bodies in England have been invited by SHAs to complete a self assessment to give an indication of the current state of preparation and to help prioritise their developmental work.

20. The Responsible Officer Regulations set out particular connections and functions for Responsible Officers in PCTS and SHAs that would be affected by the proposed changes to the NHS architecture. The Department is currently developing proposals in the light of these proposed changes. Subject to the outcome of the listening exercise in relation to the Health and Social Care Bill 2011, the Department intends to consult on its proposals before recess.

21. Training for those doctors appointed as Responsible Officers is underway and covers the statutory responsibilities and provisions of the role, obligations on a designated body to resource the Responsible Officers' work, and how to deal with potential conflicts of interest or appearance of bias. Training also addresses monitoring of clinical quality and performance, identifying concerns and quality assurance processes to support appraisal systems and organisational governance.

22. The Revalidation Support Team, the operational delivery arm of the Department's revalidation policy team, is developing practical and operational guidance for use by doctors, appraisers, Responsible Officers and others involved in the appraisal process. This takes account of the GMC's recently published appraisal framework for revalidation based on the principles laid out in Good Medical Practice and new guidance on the supporting information a doctor will be required to bring to their appraisal.

23. The new guidance on supporting information makes clear that patient and colleague feedback is expected and the GMC has developed a colleague and patient questionnaire that any doctor can use if their organisations do not already use such a tool. They have made available the latest version in draft form and expect to publish the final version with user guidance in mid 2011. As part of the second year of testing, the Revalidation Support Team are looking further at approaches to patient and public involvement in revalidation.

24. The Revalidation Support Team has developed the testing and piloting strategy for 2011–12 and this includes doctors with non-standard careers.

25. The Secretary of State wrote to the GMC in response to their consultation on revalidation in June of 2010. In the letter, he outlined his decision to extend the piloting and testing period for an additional year. The pathfinder pilots have now completed and the Department is expecting the external evaluation report by June 30th 2011. This will enable the extended year of piloting to be focused to ensure we have clear evidence for the assessment of readiness in 2012. This assessment will cover the three areas outlined in the government Command Paper in March 2011:

- Design readiness: medical revalidation is right for doctors and for patients and has been properly streamlined and made proportionate;
- Organisational readiness: the health sector has the systems in place to be able to move to implementation (Responsible Officers, appraisal, clinical governance); and,
- Business case readiness (testing the components of revalidation): so that we can have clear evidence of the benefits that revalidation will deliver and that it can be implemented in a way that is cost effective and affordable.

*Fitness to Practise Adjudication*

26. Under the previous administration plans to establish the Office of the Health Professions Adjudicator (OHPA), which would have taken over the fitness to practise adjudication function currently performed by the GMC, were well advanced. However, in December 2010, after carrying out a public consultation, the Government announced that it intended to abolish OHPA.

27. Provisions relating to the abolition of OHPA are contained in the Health and Social Care Bill 2011, which is currently being considered by Parliament.

28. In light of escalating costs in terms of the establishment of OHPA, and the improved performance of the GMC in dealing with fitness to practise matters (indicated by the very low rates of challenge to decisions in the higher courts), the Government believes that the abolition of OHPA and the modernisation of the GMC's adjudication processes (followed by a review of the position for the other health professional regulatory bodies) is the most proportionate way of enhancing independence of adjudication whilst continuing to adequately protect patients and the public. The GMC is in the process of publicly consulting on proposals it has developed to deliver modernisation of its adjudication process<sup>7</sup>.

29. Some of the potential changes that the GMC proposes would require legislative change to deliver. Following consultation, and analysis of the results by the GMC, the GMC and the Department will be working together to develop legislation and will consult publicly on this in due course.

#### *European Issues*

30. The GMC continues to make a valuable contribution to debate across Europe regarding migration of Health Professionals. It was one of three of the European regulators of doctors who collaborated on a review of Directive 2005/36/EC on the mutual recognition of professional qualifications from the perspective of Competent Authorities.

31. A key issue for the GMC has been the matter of language testing of EEA doctors. The Department and the GMC have been working closely to explore options for strengthening language checks on EEA migrants, including consideration of a role in overseeing a strengthened system of proportionate local checks in the NHS in England, through the proposed new NHS Commissioning Board. Consideration is also being given to how the new statutory role of Responsible Officer could contribute to facilitating proportionate language assessments.

#### *Fitness to practise trends: increased referrals to the GMC*

32. As CHRE recognised in their 09–10 Performance review “one of the most striking aspects of the regulators’ activity is the rapid growth in the number of fitness to practise cases reaching a final determination”. The reasons for this increase, as CHRE recognises, are likely to be multi-factorial and complex. For instance, there are more regulated health professionals than ever before, there may be a greater public awareness of the role of the health professional regulatory bodies, and the regulators themselves may well have become more efficient in holding professionals to account.

33. The GMC recently reported experiencing an increase in serious fitness to practise cases, caused by rise in referrals of nearly a third in the last year—including an increase in the proportion of referrals from statutory bodies. The GMC have reacted proactively to this by commissioning research to try and establish underlying trends. They have also launched a campaign to recruit more fitness to practise panellists to give greater capacity to hear cases.

#### *Conclusions in relation to the GMC*

34. CHRE's Performance Review for 09–10 (published July 2010) and latest fitness to practise audit (published March 2011) suggest that the GMC is fully and effectively discharging its statutory duties to deliver patient and public protection. It is also working closely with Government and European partners to further the development of health professional regulation in the UK and across Europe.

#### PERFORMANCE OF THE NMC

##### *Progress since the 2008 CHRE Special Report into the NMC*

35. On 14 March 2008 the then Minister of State for Health Services, Ben Bradshaw MP, wrote to the Chief Executive of CHRE asking it to expedite its annual performance review of the NMC to address “the central question of whether the NMC is fulfilling its statutory functions”. This step was taken following a debate in Parliament in which concerns were raised regarding the NMC. Following this letter, CHRE reported in June 2008 making recommendations for improvements. The NMC subsequently implemented an action plan to address these issues.

36. The leadership of the NMC has changed substantially since the 2008 Special Report by CHRE. The NMC appointed a new chair (Professor Tony Hazell) on 1 January 2009. It moved to an independently appointed Council (made up of equal lay and registrant members) from the same date, and it appointed a new chief executive (Professor Dickon Weir-Hughes) on 2 November 2009.

37. In February 2010, CHRE published its first annual audit of the initial stages of the health professional regulatory bodies’ fitness to practise processes. The period covered by this audit was 1 April 2008–31 March 2009, before recent changes in governance and leadership at the NMC had been made. Many of the points

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<sup>7</sup> See: [http://www.gmc-uk.org/concerns/fitness\\_to\\_practise\\_consultations.asp](http://www.gmc-uk.org/concerns/fitness_to_practise_consultations.asp)

raised were historic, but CHRE raised concerns that the processes used by the NMC did not appear to have improved significantly since the 2008 Special Report.

38. In April 2010, the NMC invited CHRE to undertake a review of progress in relation to their tackling of the Special Report's recommendations. CHRE reported their findings in January 2011.<sup>8</sup> This Review of progress noted that significant improvements have been made since the 2008 Special Report, including the introduction of an electronic case management system (CMS) and improved training for fitness to practise panellists. However, CHRE considered that improvements still needed to be made, especially in the areas of caseload management and the implementation of standard operating procedures.

#### *CHRE 09–10 Performance Review*

39. CHRE's headline assessment in its July 2010 report was that the NMC, in common with all the regulators, are meeting their statutory obligations<sup>9</sup>. Their main conclusions as to the performance of the NMC were as follows:

“Nursing and Midwifery Council continues to maintain good performance across a number of its functions including the development and communication of its standards ...[and]...continues to make progress in those areas of weakness identified in our Special Report for the Minister of State for Health Services particularly in relation to case progression. However, we remain concerned about the customer service provided by the fitness to practise department and the quality and consistency of decisions made and recorded by fitness to practise panels.”

40. In the July 2010 report CHRE reflected back on recommendations they had made in relation to the NMC in the previous year, and progress as to implementation. In their performance review for 08/09 CHRE identified eight areas where they were looking for improvement from the NMC (e.g. reducing the time it takes to process fitness to practise cases, implementation of IT based case management).<sup>10</sup> CHRE reported that they were “satisfied” as to progress in these eight areas, but that there was “room for improvement” in others (such as consistency and quality of decision making in fitness to practise cases and improving the NMC's culture of customer focus).<sup>11</sup>

41. Whilst fitness to practise issues inevitably get much focus because of the close nexus to public safety, the 09/10 Performance Review also acknowledges wider successes of the NMC, such as:

- its review of pre-registration nursing education which was informed by specific patient groups in partnership with organisation such as Mencap and the Alzheimer's Society;
- the fact it has maintained good performance across a number of its functions including the development and communication of its standards;
- its good performance in terms of processing and checking registration applications; and,
- its continued improvements in terms of approaches to stakeholder engagement.

#### *CHRE findings in relation to the NMC in their March 2011 fitness to practise audit*

42. In its latest fitness to practise audit CHRE again raised concerns issues in relation to the handling of fitness to practise cases at the NMC. CHRE were concerned about the NMC's performance in dealing with fitness to practise concerns in a number of areas, including: inconsistent reviewing of new cases to identify and prioritise high risk cases, poor record keeping, poor customer service, delayed decision making, concerns about inadequate investigation, and poor analysis by decision-makers. However, it is important to recognise (as CHRE did in this audit) that improvements have taken place in this area in comparison to past years, and that further improvement work is ongoing.

43. Following publication of the March 2011 audit, Ministers have sought, and been given, written assurances by the NMC's leadership that necessary actions are and will be taken to address these concerns. The NMC are providing quarterly updates to CHRE on progress made.

#### *Revalidation*

44. *Enabling Excellence* asked the regulatory bodies for the non-medical healthcare professionals to continue to develop the evidence base that will inform their proposals for revalidation.

45. The NMC is the biggest healthcare professionals' regulator and has significant logistical challenges due to the number of registrants (665,599 as of March 2010) and the fact that considerable numbers do not work within the NHS.

46. For the past two years, the NMC has concentrated on developing a robust evidence base for revalidation by commissioning research to assess the potential risks relating to the practice of their respective registrant

<sup>8</sup> See: [https://www.chre.org.uk/\\_img/pics/library/110124\\_NMC\\_Progress\\_Review\\_Report.pdf](https://www.chre.org.uk/_img/pics/library/110124_NMC_Progress_Review_Report.pdf)

<sup>9</sup> See: [https://www.chre.org.uk/\\_img/pics/library/100806\\_Performance\\_review\\_report\\_2009-10\\_tagged\\_1.pdf](https://www.chre.org.uk/_img/pics/library/100806_Performance_review_report_2009-10_tagged_1.pdf)—at para 8.1

<sup>10</sup> For the eight areas see: [https://www.chre.org.uk/\\_img/pics/library/100806\\_Performance\\_review\\_report\\_2009-10\\_tagged\\_1.pdf](https://www.chre.org.uk/_img/pics/library/100806_Performance_review_report_2009-10_tagged_1.pdf)—at para 15.3

<sup>11</sup> For these areas see: [https://www.chre.org.uk/\\_img/pics/library/100806\\_Performance\\_review\\_report\\_2009-10\\_tagged\\_1.pdf](https://www.chre.org.uk/_img/pics/library/100806_Performance_review_report_2009-10_tagged_1.pdf)—at para 15.4

groups. This research has included looking closely at what their fitness to practise data (historical and current) could tell them about the risk. This piece of work is essential in allowing the NMC to develop a risk-based and proportionate proposal for a framework for revalidation.

#### *Conclusions in relation to the NMC*

47. It is clear from the detailed assessments of CHRE in a number of reports that there are still outstanding issues at the NMC, especially in relation to handling of fitness to practise cases. It is further clear that changes of governance and leadership in 2009 have led to considerable improvements, and that the NMC's wider performance is on an upward trend. The energy and tenacity that the NMC's current Chief Executive has brought to the organisation has certainly contributed to this.

48. However, neither the Department, CHRE, nor indeed the NMC are complacent. There is still more work for the NMC to do to get to the stage where current areas of concern surrounding fitness to practise work are resolved, as recent activity in this area is yet to fully yield substantial improvements.

49. The NMC are currently engaged in constructive discussions with the Department as to whether and how legislative change could support continued improvement in their fitness to practise function could deliver further benefits.

50. CHRE continues to receive quarterly progress updates on the NMC's actions in these areas. The forthcoming CHRE performance review for 10/11 will be a further indication as to whether previous progress is being effectively maintained and built upon. In the Department's view the NMC has significant challenges facing them and are working hard to tackle them. Therefore, it is essential that their focus is maintained on meeting their existing statutory duties.

*June 2011*

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### **Written evidence from the General Medical Council (GMC 02)**

#### **INTRODUCTION**

1. We welcome the opportunity to strengthen our accountability to Parliament by reporting directly to the Health Select Committee on all areas of our work and we look forward to giving oral evidence to the Committee on 14 June 2011.

2. The GMC's 2010 Annual Report will be approved by Council on 8 June 2011. We will submit a copy to the Committee as soon as possible after this date in order to give an overview of our work last year.

3. In addition, we have compiled this memorandum for the Committee, which provides a summary of our accountability to Parliament as well as an update on our performance in some key areas, such as revalidation, fitness to practise and improving our efficiency.

#### **OUR PURPOSE**

4. The General Medical Council (GMC) is the independent regulator for doctors in the UK. Our main statutory objective is "to protect, promote and maintain the health and safety of the public" as set out in the Medical Act 1983 (as amended) by ensuring proper standards in the practice of medicine.

5. We are a patient safety organisation and our role as to protect patients by making sure that only doctors who are fit to practise are allowed to do so.

6. We aim to deliver regulation that:

- (i) Is independent, fair, efficient and effective.
- (ii) Raises standards and enhances patient safety.
- (iii) Fosters the professionalism of doctors.
- (iv) Encourages early and effective local action.
- (v) Commands the confidence and support of all our key interest groups.

#### **OUR ACCOUNTABILITY TO PARLIAMENT**

7. The Medical Act 1983 provides the legal basis for everything that we do and gives us specific powers and duties to carry out our functions. Parliament updates our legislative framework in order to enable us to adapt to changing circumstances and effectively fulfil our statutory obligation.

8. The GMC is accountable to Parliament, through the Privy Council, for the exercise of our statutory duties. We are required to present an annual report to Parliament on the conduct of our business and on the efficiency and effectiveness of our fitness to practise arrangements.

9. In addition, the Council for Healthcare Regulatory Excellence (CHRE) conducts a thorough annual performance review of our work. They measure our performance against a set of standards and report their findings to the UK Parliament.

10. As a registered charity, the GMC is also required to submit reports to the Charity Commission setting out how our money is spent and how resources have been used.

11. Given our responsibility for assuring patient safety we think that it is important that there is a mechanism for greater parliamentary scrutiny. We have been calling for this for a number of years and it was a key recommendation of the 2007 White Paper *Trust, Assurance and Safety*. We therefore strongly welcome the decision from the Health Select Committee to call the GMC to give evidence on all areas of our work.

#### PROGRESS REPORT ON OUR KEY AREAS

12. The GMC's eight strategic aims are outlined in our Corporate Strategy 2010–2013. These are:

- (i) to continue to register only those doctors that are properly qualified and fit to practise and to increase the utility of the medical register.
- (ii) to give all our key interest groups confidence that doctors are fit to practise.
- (iii) to provide an integrated approach to the regulation of medical education and training through all stages of a doctor's career.
- (iv) to provide doctors with relevant up-to date guidance on professional standards and ethics.
- (v) to develop more effective relationships with delivery partners in order to achieve an integrated approach to medical regulation in the UK.
- (vi) to help shape the local, UK, European and international regulatory environment through effective engagement with decision makers, other regulators and key interest groups.
- (vii) to continue to use our resources efficiently and effectively.
- (viii) to deliver evidence-based policies that demonstrate "better regulation" principles, and promote and support equality and diversity.

13. We publish a Business Plan each January, which sets out how we plan to deliver on these priorities in the year ahead, and an Annual Report published each June that charts our progress and documents our constitution and financial statements for the previous year.

14. The GMC's 2010 Annual Report is due to be published on 8 June 2011. Once it is approved by Council we will submit a copy to the Committee in order to give an overview of our work in 2010. In addition to this, we thought that it would be useful to provide an update to the Committee in this memorandum on three specific areas of our work: revalidation, fitness to practise and improving our efficiency.

#### REVALIDATION

##### *Progress towards implementation*

15. Revalidation is the GMC's number one priority and we are pleased that we have now moved into the implementation stage.

16. We are committed to working closely with our partners—including the four UK health departments, the NHS and other healthcare providers—to ensure that all the elements to support the introduction of revalidation are in place and fit for purpose. This commitment is demonstrated in the joint *Statement of Intent* that we signed with the four UK health departments in October 2010 and which set out our shared commitment to launching a system of revalidation by the end of 2012 that is feasible, flexible, proportionate and cost-effective.

17. We have set up a UK Revalidation Delivery Group, which consists of the four health departments and the GMC. This meets every month to discuss progress, evaluate readiness and monitor risks and issues.

18. We have also begun to develop the necessary secondary legislation to support the implementation of revalidation. We are liaising with the Department of Health to ensure that they have enough time to review and to take the legislation through Parliament before sign off by the Privy Council in 2012.

19. The Secretary of State will make an assessment of whether the system is ready to support revalidation in the summer of 2012 and we are working with our partners to make sure that he has all of the information he needs. We wrote to the four UK health departments in March 2011 to ask for further information on how they are assessing progress towards readiness. Their assessments should provide the assurance that the Secretary of State will need before he agrees to "switch on" the relevant legislation in late 2012 to enable us to begin revalidating doctors.

##### *Our response to the Health Select Committee report on revalidation*

20. The GMC submitted a detailed written response to the Health Select Committee's report, *The revalidation of doctors*, which was published by the Committee on 12 May 2011. In our response we welcomed the Committee's recommendations, particularly the demand that revalidation be in place by 2012.

21. The Committee's report stated that 'now that "late 2012" has been set as the date of implementation, we look to the GMC to ensure that there are no further delays and that the current target date is achieved'. We are confident that revalidation can begin in late 2012. The successful implementation of revalidation does, however, depend on the continuing co-operation, commitment and hard work of all our partners.

22. The Committee's report also rightly highlighted areas where more work is needed. On remediation, we remain committed to supporting the four health departments who are taking the lead on this important issue. We are also in the process of developing guidance for Responsible Officers, which will build on existing advice for Medical Directors and other health professionals about the types of concerns that should be referred to the GMC.

#### FITNESS TO PRACTISE

23. The purpose of the GMC's fitness to practise procedures is to protect patients and the public by removal or restriction of a doctor's right to practise where necessary. The courts have made it clear that our focus is on a doctor's future fitness to practise and not on disciplining doctors for past misconduct. It is also not part of our remit to provide redress for complainants. Where appropriate, in cases that do not require GMC action on registration, we redirect the complaint or enquiry to the NHS or other healthcare providers.

#### *Performance assessment*

24. In 2010, we met our targets to conclude 90% of fitness to practise cases within 15 months, to review 100% of doctors with conditions or undertakings attached to their registration before being returned to unrestricted registration, and to begin 100% of Investigation Committee hearings within two months of referral. We also changed our service target for commencing an Interim Orders Panel hearing following a referral from four to three weeks and achieved this more challenging service target throughout the year.

25. We experienced a 24% increase in the number of enquiries about a doctor's fitness to practise in 2010 compared to 2009. This increase led to a 19% increase in the caseload for enquiries that appear to require a GMC investigation into potentially serious concerns. We have responded to this by increasing our investigation resources and improving our efficiency and productivity.

26. Since late 2009, we have also experienced an increase in both the number of cases being referred to public hearings and the average length of hearings. We have therefore taken steps to increase our hearing capacity and make more efficient use of our resources.

27. We also experienced a rise in the number of doctors applying to register with the GMC in 2009. Despite a 6.6% rise in the number of doctors granted registration, however, we still met our target of registering 95% of applications within five working days

#### *Proposed reforms to our Fitness to Practise procedures*

28. At the start of 2011, we commenced a programme of fundamental reform of our fitness to practise procedures. We have undertaken two recent consultations. The first, which closed on 11 April, contains proposals that aim to provide quicker resolution in cases and less stress and anxiety for all concerned while retaining transparency and, above all, continuing to protect patients.

29. The consultation recommended that doctors could accept sanctions, including suspension and erasure, without their cases going to a hearing. For those doctors who do not accept the sanction proposed by the GMC, or where there is a significant dispute about the facts, cases would still be referred for a hearing.

30. Patient protection would be the driving force behind the new system but where possible it would avoid subjecting doctors and patients to the stress of public hearings. It would also be transparent—even when a case did not end with a hearing, the concerns and any sanctions would still be published on the GMC website. We would also make sure that the media is promptly notified about the outcome of cases and that they and the public retain the opportunity to scrutinise decisions.

31. The consultation document also proposes a speedier process for dealing with doctors convicted of serious crimes such as murder and rape. We believe that those who have committed such crimes are not fit to be doctors and, following a conviction, there would be a presumption of erasure from the register, following representations made by the doctor.

32. The consultation closed on 11 April 2011 and we expect to report back on the main findings of this consultation in June 2011.

#### *Modernising and repositioning adjudication within the GMC*

33. In December 2010, the Government confirmed its intention to abolish the Office of the Health Professions Adjudicator (OHPA), which would have taken over the GMC's adjudication function in April 2011, and to take forward steps to enhance the separation between the GMC's investigation role and its adjudication function.

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34. In response, we are currently consulting on proposals for modernising and repositioning adjudication within the GMC in order to enhance its separation, efficiency and effectiveness.

35. We propose to establish a Medical Practitioners Tribunal Service which would be responsible for running hearings and for decisions by panels which in future would be called medical practitioner tribunals. The Tribunal Service would be separate from our investigation of cases and our presentation of them to tribunals. It would be led by an independently appointed Chair with significant judicial experience.

36. Our consultation also contains proposals for a number of reforms that will modernise the way hearings are run, speeding up the adjudication process and reducing the stress for all those involved. These proposals include the use of legally qualified chairs, greater use of written evidence and more effective management of cases as they are prepared for hearings.

37. This consultation will close on 13 June 2011 and we expect to report on the main findings later this year.

## IMPROVING OUR EFFICIENCY

### *Efficiency savings*

38. We are committed to providing value for money and, as far as we can, control our costs.

39. We have established a Performance Board to develop and oversee an organisation-wide efficiency programme to deliver on our commitment to ongoing business improvement and value for money, aiming to deliver year-on-year gains of 3–5% between 2010 and 2013.

40. In 2010, we achieved total annualised efficiency gains of £8.3 million, which represents approximately 9% of our budget for the year. Around £6.6 million of this figure relates to cashable savings which have been incorporated into our 2011 budget.

41. Major savings were delivered through projects to improve our efficiency, including the further expansion of our in-house legal team, changes to the number of panellists who would be required to protect the panel quorum for fitness to practise hearings, a rent review on our leased buildings, a review of travel costs, and economies of scale following the merger with the Postgraduate Medical Education and Training Board (PMETB). Further savings were delivered by conducting specific business improvement projects within directorates.

### *Reducing the cost of regulation for doctors*

42. Partly as a result of these savings, we have been able to introduce a reduction in registration fees for doctors at the start of their careers, a freeze in the annual retention fee for all doctors, an increase in the threshold for eligibility for the lower income discount, and a reduction in certification fees. These measures were all introduced in 1 April 2011.

43. Our move to reduce our regulatory fees was explicitly welcomed in the Government's command paper, *Enabling Excellence—Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*, which was published in February 2011. This document also stated that 'Given the need for pay restraint amongst the health and social care professions, the Government would not expect registration fees to increase beyond their current levels, unless there is a clear and robust business case that any increase is essential to ensure the exercise of statutory duties'.

44. Looking forward, we will do whatever we can to keep fees to a minimum while continuing to help improve standards and protect patients.

## CONCLUSION

45. We hope that the Committee finds this short memorandum useful ahead of the oral evidence session on 14 June 2011.

46. As stated above, we will also submit a copy of our 2010 Annual Report to the Committee as soon as it has been agreed by Council.

*June 2011*

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### Supplementary written evidence from the General Medical Council (GMC 02A)

1. This memorandum provides information that was requested by the Health Select Committee during the oral evidence session with the GMC on Tuesday 14 June 2011. It is divided into three categories:

- Legislative changes that will help the GMC to further protect patients
- BME doctors entering our fitness to practise proceedings
- Individual fitness to practise cases that were raised by the Committee

#### LEGISLATIVE CHANGES THAT WILL HELP US FURTHER PROTECT PATIENTS

2. The Medical Act 1983 provides the legal basis for everything that we do and gives us specific powers and duties to carry out our functions.

3. Parliament updates our legislative framework in order to enable us to adapt to changing circumstances and effectively fulfil our statutory obligations.

4. The Government recognises the constraints that this can place on the professional regulators' ability to adapt and modernise. In the recent Command Paper, *Enabling Excellence*, the Government states that "the constraints on Government resources mean that only the most pressing issues are acted upon and the process for making these changes takes about two years. Consequently, regulators are frequently unable to make important changes that would allow them to improve their performance, work less bureaucratically, reduce costs to registrants and respond more fairly and effectively to both public and professional concerns".<sup>12</sup>

5. In recognition of this problem, the Government has commissioned a simplification review of the legislative framework for professional regulation and they propose to "set in statute a high level legislative framework to provide the powers and duties of the professional regulatory bodies and the outcomes required from them, it would be for the regulators themselves to decide on, and take responsibility for, how these outcomes were delivered in practice and for ensuring that they were compatible with human rights and other legislation".<sup>13</sup>

6. We welcome the Government's position and are optimistic that in the long-term this will allow us to improve our ability to protect patients.

7. There are however a number of areas where legislative changes are needed more quickly. As requested by the Committee, we have outlined below a number of our priority areas where we would like to see changes to the Medical Act in order to improve our ability to protect patients.

8. The majority of the required changes to primary legislation identified below could be achieved through Section 60 of the Health Act 1999 by the introduction of appropriate statutory instruments.

#### *Independence of panels and a right of appeal for the GMC*

9. As discussed at the oral evidence session, we have consulted on proposals to create a greater degree of separation between investigation and adjudication within the GMC. Central to the consultation are the proposals to establish a Medical Practitioner Tribunal Service (MPTS) and to introduce a right of appeal for the GMC. These proposals have been put forward in light of the Government's decision to abolish the Office of the Health Professions Adjudicator (OHPA).

10. Fitness to practise panels already make their decisions independently but we propose to further strengthen the separation between our investigation and adjudication work. Setting up the MPTS will help us to do that, ensuring it is clearly separate from the rest of the GMC. All aspects of operational management of adjudication will be placed under the control of the Chair of the MPTS and we will separate the management of the rest of our fitness to practise activity from that of adjudication.

11. In addition, we also propose to introduce a power of appeal for the GMC to the High Court with regard to determinations reached by panels. Panels can and sometimes do make decisions that we do not agree with. This demonstrates their independence, but we believe that we should be able to appeal in cases where we believe that the decision was not reasonable and expose the public to risk. This would be similar to the power currently held by the Council for Healthcare Regulatory Excellence (CHRE) and it would reinforce the clear separation of investigation and adjudication within the GMC. We believe that having a right of appeal will give the public greater confidence in the system and in our ability to act in their interests.

12. The consultation closed on 13 June 2011. Subject to the outcome of the consultation, legislative change will be needed to bring in these proposed changes.

#### *Speeding up our fitness to practise procedures and improving "voluntary erasures"*

13. The GMC has proposed to develop a simpler and speedier fitness-to-practise system. Our proposals include plans that would see doctors accepting sanctions, including suspension and erasure, without their cases

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<sup>12</sup> *Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff*, Department of Health, 16 February 2011

<sup>13</sup> *Ibid*

going to a hearing. For those doctors who do not accept the sanction proposed by the GMC, or where there is a significant dispute about the facts, cases would still be referred for a hearing.

14. Patient protection would be the driving force behind the new system but where possible it would avoid subjecting doctors and patients to the stress of public hearings.

15. We also propose to no longer use the term “voluntary erasure” where we remove a doctor’s name from the register where there are fitness to practise concerns. That description does not properly reflect the fact that, in such cases, the GMC believes it is appropriate that the doctor’s registration is restricted or removed and the doctor accepts our proposal. As part of the consultation we received a number of suggestions about the language we use to describe the outcomes of discussions with doctors. We tentatively favour the term “Decided by the GMC and accepted by the doctor”, which was proposed by a range of our interest groups.

16. In cases where the doctor’s name has been erased by mutual agreement we would ensure that the sanction accepted by the doctor is published in full on our website. We also propose to publish a description of the issues which were put to the doctor and any mitigation (information provided by the doctor that reduces the seriousness of the apparent concern) supported by evidence that we have taken into account.

17. We consulted on these proposals from 17 January 2011 until 11 April 2011. The responses to our consultation show support for our plans. Legislative change will be needed to progress many of the proposed changes.

#### *Assessing the language skills of doctors from the EEA*

18. As stated during the oral evidence session, through our joint work with the Department of Health we have developed a proposal for a UK wide scheme that would help us provide greater assurance to patients that doctors practising in the UK are able to speak English and have the necessary skills to practise safely.

19. We believe that this system requires a change to the Medical Act and through our close work with the Department of Health we expect these changes will be brought before Parliament in due course.

#### *Quality assurance of medical schools overseas*

20. Several UK medical schools have launched initiatives to establish campuses outside the UK to deliver undergraduate medical education and training overseas leading to a recognised UK medical qualification.

21. Although the 1983 Act is couched in terms which require the GMC to quality assure medical education provided overseas, such initiatives were not contemplated when the legislation was originally drafted.

22. Removing the requirement for the GMC to quality assure programmes delivered overseas would not prevent UK medical schools from using their expertise to establish campuses and courses overseas and exploiting the business opportunities that flow from doing so. We fully support them in those endeavours.

23. We are working with the Department of Health on a request we made in 2010 to amend the Act to remove the overseas requirement. Until and unless such time as the Act is amended in that way, we accept that we remain responsible for quality assurance of the overseas campuses of UK medical schools.

#### **BME DOCTORS ENTERING OUR FITNESS TO PRACTISE PROCEEDINGS**

24. The GMC is committed to ensuring that our processes and procedures are fair for all doctors, including those from BME backgrounds and those who trained overseas.

25. We audit key points in our fitness to practise procedures to ensure that cases are handled in a way that is transparent, consistent and appropriate in terms of our guidance and criteria. All decisions made by fitness to practise panels are fully documented and subject to audit.

26. Our internal quality assurance and audit processes include a team of internal auditors to check compliance with systems and processes. We undertake quality assurance of decisions made at all stages of our fitness to practise procedures including decisions taken by panels. We check that the decisions made follow the framework within which panels work.

27. The GMC has commissioned a number of studies to investigate the proportion of doctors from minority ethnic groups that enter our fitness to practise procedures. In recent years, it has been possible to conduct more detailed and thorough investigations following improvements to the quality and coverage of our ethnicity data through a survey of all doctors on the Medical Register as well as an overall improvement in our fitness to practise documentation and data management systems.

28. Recent research undertaken by Professor Charlotte Humphrey of Kings College, London, concluded that there is a clear link between whether a doctor qualified outside the UK and the likelihood of a “high impact” fitness to practise outcome. The research also concluded that there is no clear association between ethnicity and outcome.

29. This study was based on a secondary analysis of the cases of just under 7000 doctors referred to the GMC in a 2 year period between 2006 and 2008, looking at the association between two different factors, ethnicity and place of medical qualification.<sup>14</sup>

30. Further to this study, our 2009 data demonstrates that when focusing in on those doctors that gained their Primary Medical Qualification (PMQ) from a medical school in the UK, there is no evidence of overrepresentation of BME doctors in our fitness to practise procedures. Of the doctors registered with the GMC who gained their PMQ from a medical school in the UK, 14% are from a BME background. Of the complaints we receive about UK PMQ doctors, only 11.5% are regarding doctors with a BME background. Furthermore, of the doctors registered with a UK PMQ who have had a full hearing, only 9.8% are from a BME background.

31. We are working to gain a better understanding of why some groups of doctors, in particular those who qualified outside the UK, are over represented both in the proportion of complaints we receive and in our fitness to practise procedures.

32. We would be happy to keep the Committee updated on this issue.

#### FITNESS TO PRACTISE CASES RAISED BY THE COMMITTEE

33. Members of the Committee asked about five specific fitness to practise cases on Tuesday 14 June 2011.

34. The cases against Dr Ahmed Shaheen, Mr Ivan Phair and Dr Bishnu Singh were raised in the written evidence submitted by Sir Donald Irvine as examples of when the GMC had sought erasure but where the Panel's determination decided otherwise. Members of the Committee requested further information about the outcome of these cases.

35. Rosie Cooper MP also asked about the voluntary erasure of Dr Owen Gilmore and Mr Nigel Sacks.

36. Included below is a summary of the outcomes for each of these cases.

37. Alongside this memorandum we have also submitted to the Committee the panel's full determination of the Dr Ahmed Shaheen, Mr Ivan Phair, Dr Bishnu Singh and Mr Nigel Sacks cases.<sup>15</sup> These four documents are also available on our website ([www.gmc-uk.org](http://www.gmc-uk.org)). These documents provide the full picture of what the panels took into account and how they reached their determination. Dr Gilmore's erasure was granted by the Case Examiners and so there is no public determination.

#### *Dr Ahmed Shaheen (GMC number: 3047761)*

38. The panel found that Dr Ahmed Shaheen's actions amounted to misconduct and that his fitness to practise was impaired. The panel determined that Dr Shaheen should be suspended from the medical register for the maximum period of suspension available, 12 months.

39. The Panel considered it to be a borderline case between suspension and erasure. The Panel concluded that the doctor's conduct, though falling far below the standard expected of a registered medical practitioner, was not fundamentally incompatible with continued registration having balanced the doctor's actions against the mitigation put forward. Whilst the Panel noted that it is unlikely that the doctor would ever return to unrestricted medical practice, it was of the view that it would not be in the public interest to deprive patients indefinitely of the doctor's services in non-surgical aspects of the practice of obstetrics and gynaecology.

40. Before the end of the 12 month suspension period, a Panel will meet to review the case. At that hearing, the Panel will wish to be satisfied that the doctor has gained full insight into their behaviour.

#### *Mr Ivan Phair (GMC number 2644291)*

41. The Panel determined that Mr Phair's fitness to practise was impaired by reason of deficient professional performance and that the doctor's registration should be subject to 17 different conditions for a period of 18 months.

42. These conditions include an obligation to obtain the approval of the GMC before accepting a post as a doctor, to inform the employer that their registration is subject to conditions, to allow the GMC to exchange information with their employer and to inform the GMC if the doctor applies for medical employment outside the UK.

43. During this 18 month period the doctor is also obliged to work with a Postgraduate Dean to formulate a Personal Development Plan specifically designed to address their deficiencies, to provide a copy of this to the GMC and to meet regularly with the Dean on a regular basis to discuss progress towards achieving the aims set out in your Personal Development Plan.

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<sup>14</sup> Charlotte et al (2009). Clarifying the factors associated with progression of cases in the GMC's Fitness to Practise procedures: Full Research Report ESRC End of Award Report, RES-153-25-0101. Swindon: ESRC

<sup>15</sup> Not printed here

44. If at any time the doctor is providing medical services that require GMC registration, they must place themselves and remain under the supervision of an educational supervisor.

45. A Panel will review the doctor's case at a hearing to be held before the end of this 18 month period of conditional registration. The Panel will then consider whether it should take any further action in relation to the doctor's registration.

*Dr Bishnu Singh (GMC number 2457563)*

46. The Panel determined that Dr Singh's fitness to practise was impaired by reason of his deficient professional performance and imposed 18 conditions on the doctor's registration for a further period of 12 months.

47. The conditions are similar to those listed above for Mr Ivan Phair. In addition, further conditions were imposed that confined the doctor from undertaking any private practice, working as a locum or undertaking any out-of-hours work or on-call duties.

48. The Panel determined that the doctor should have the opportunity to demonstrate to the Panel that they are able to remedy the deficiencies in their practice. Before the end of the 12 month period of conditional registration a Panel will meet to review the doctor's case.

*Mr Owen Gilmore (GMC number 0290229) and Mr Nigel Sacks (GMC number 3390036)*

49. Rosie Cooper MP referred to the voluntary erasures granted to these two doctors during the oral evidence session on 14 June 2011.

50. Each doctor submitted extensive specialist medical evidence to the effect that their health prevented them from participating in the Fitness to Practise Panel proceedings. The GMC obtained independent specialist medical advice which confirmed the opinions in each case. In Mr Sacks' case, the evidence was that this was situation-specific—the ill-health arose from the prospect of facing the proceedings. Mr Sacks had earlier run a similar argument at Southwark Crown Court when successfully applying for a permanent stay of criminal charges on related matters.

51. The inability of the doctors to participate in the proceedings raised severe doubt as to whether the Fitness to Practise Panel could be conducted in a way that could be regarded as fair to the defendant doctors. In Mr Sacks' case, the Panel decided that it could not, a decision that was consistent with the view taken previously by the criminal court. We kept the Australian regulator updated about his case at each stage.

52. In Dr Gilmore's case, the Case Examiners decided to accept an application for voluntary erasure based on his ill-health shortly before the hearing was due to open.

53. The cases illustrate the often very complex legal hurdles that can arise in a process of prosecution of detailed factual charges and lengthy evidence before a quasi-judicial tribunal. Acceptance by the GMC of a doctor's application for erasure can achieve a quicker guaranteed outcome efficiently without the need to overcome such hurdles, and without the risk that the eventual outcome is less than erasure.

*June 2011*

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**Written evidence from Sir Donald Irvine (GMC 03)  
(President of the GMC, 1995–2002)**

*“Patients need good doctors. Good doctors make the care of patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity”. GMC, Good Medical Practice, 2006*

**SUMMARY**

1. The baseline (the bar) used today by the GMC to distinguish between good and problematic practice in its fitness to practise procedures—and revalidation when it is introduced—is too low to protect patients properly. It must be raised, to reflect the GMC's commitment to the public, set out in the introduction to its guidance Good Medical Practice, which tells patients that the standards described are what “they can expect” from doctors registered with the GMC(1). It is necessary also to protect the good name of the profession.

2. The vast majority of doctors do indeed provide a good standard of practice and care. It is the patients of those who do not who need protection.

3. This paper sets out how the GMC and the Health Select Committee together can provide a lasting solution to this serious, longstanding weakness in the regulation of British doctors.

## INTRODUCTION

4. Under the Medical Act, 1983 the main function of the GMC is to “protect, promote and maintain the health and safety of the public”. The GMC does this by keeping registers of those whom it has licensed and certificated to practise by virtue of their generic and specialty specific medical knowledge, skills and ethical standards. It has the power to remove those holding a license to practise who may later fall short of the expected standards.

5. Today, the GMC’s Good Medical Practice provides a widely respected description of the qualities expected of a doctor licensed and certificated by the GMC under the Medical Act. It gives clear guidance on what doctors can and cannot do, and warns of the possible consequences for their registration of being in breach. It is the foundation of all medical training, and will be the basic template for revalidation. It is used in the GMC’s fitness to practise procedures as the yardstick against which the sufficiency—the “goodness”—of a doctor’s conduct or performance is judged. It is these procedures which will be used to make final decisions about doctors whose eligibility to be revalidated is in doubt.

6. When the guidance was first published 16 years ago the choice of the word “good” was quite deliberate. The Council wanted the public, patients and profession to know that whilst doctors should aspire to excellence, a *good* standard of care should be the general rule expected of every conscientious doctor. It knew that British patients were realistic and tolerant, and so would not expect that only “the best” would do for them; equally, however, the GMC had learnt from some painful experiences and rising patient pressure that there were limits to public tolerance, and that no right-minded person would knowingly agree to be looked after by a “less than good”, consistently underperforming doctor.

7. Patients today would anticipate that the standards in Good Medical Practice are mandatory since they are linked to registration (and now licensure) which, by definition, is an obligatory requirement for practice. Furthermore, they think that good really does mean “good”, and so by inference expect the bar delineating goodness from something less acceptable to reflect the highest common factor of agreement practical across the members of the profession who take their obligations to their patients seriously, not the lowest common denominator that can be found.

8. Doctors, on the other hand, have had much more diverse ideas. Conscientious doctors subscribe to the general principles of Good Medical Practice provided that they can exercise appropriate and reasonable discretion in their everyday application in practice. Others, however, have adopted a much more self-protective stance (see also paragraph 19 below). This ambiguity across the profession has been reflected in the medical trade unions which, whilst very supportive of good practice, have nevertheless successfully protected all but the most flagrantly underperforming doctors from sanction by striving to keep the bar for goodness as low as possible consistent with what they think the public will just tolerate. A good example was the successful defeat by the profession’s representatives of a Private Members Bill brought by Mr. Nigel Spearing in 1984, which he brought after the disastrous case of Alfie Winn, a boy who died from meningitis. His Bill would have had the effect of raising the bar; questions raised subsequently on the same subject by the Privy Council were indicative of public concern at that time. For a more recent example relating to revalidation see paragraph 22.

9. The gap between the two positions is wide. It exposes some patients to avoidable risk and undermines public trust in the profession. It urgently needs to be narrowed as much and as soon as possible. It is the profession which must move towards the public’s expectations because, as I shall show, the lower end of the spectrum of conduct and performance evident in some of the fitness to practise decisions made today cannot be justified in terms of patient safety, fairness and respect for patients, and in the conditions and demands of modern practice. In other words, as things stand the bar is far too low.

10. I would like the Health Select Committee to focus on securing resolution. This needs to happen quickly. The Committee can help in three ways. First, it can make it plain to the GMC and the profession that the GMC’s duty to protect patients comes before all else. The GMC has got to show that it is making a serious effort to do so by raising the bar for the fitness to practise procedures and revalidation. To this end the Health Committee gave a timely reminder (Paras 26 and 31) in its recent Report on the Revalidation of Doctors (2). Second, it could help the GMC achieve this by signaling to the profession that Parliament expects the guidance from the GMC to be taken seriously, that in promulgating such guidance and the means of implementing it effectively, the GMC is carrying out its duty under the Medical Act. And third, it could encourage Parliament to stand up more openly for patients, for Parliament to assert that it is optimal standards of practice that it expects for patients, and so counter the powerful weight of self-protective medical trade union pressure. After all the Medical Act is Parliament’s legislation; the GMC should not have to fight the good fight for patients alone.

11. If this cultural impediment can be removed, once and for all, I am confident that the medical profession has within it the knowledge, skills and general sense of professionalism needed to put the regulation of doctors on a sure footing, to put beyond question any doubts there may be about why people should be able to trust any UK licensed doctor. For patients and their families everywhere that would be a huge relief.

## 12. *Illustrative Cases: The Demonstration of the Low Bar in Action*

I have taken three cases from the GMC's list of recent fitness to practise decisions recorded on the GMC's website in an eight week period in February and March 2011. I do not know how representative these cases are of the total considered in fitness to practise; the GMC publishes no relevant analysis on its website.

13. Dr A, a consultant gynecologist had serious problems with his clinical practice and standards of professional conduct between 2001 and 2007. The panel, finding misconduct, said that his conduct "fell far below the standards expected of all registered practitioners". They went on to say that the recorded behaviour would be "regarded as deplorable by the public, patients and fellow practitioners". Lawyers for the GMC sought erasure for his misconduct. However the panel, after hearing mitigation, said that suspension for a year would suffice. They concluded that his conduct, although "falling far below the standard of a registered medical practitioner, is not fundamentally incompatible with continued registration". Before the year is up there would be a review hearing. In the information the panel sought from the doctor for the review, no objective assessment of competence was specified.

14. Mr. B has been a consultant surgeon from 2002-current. In 2008 his NHS trust, concerned about deficiencies in his practice, referred him to the GMC and then suspended him from clinical duties. Mr. B had a GMC performance assessment in June/July 2010. The assessment revealed serious deficiencies in his performance in several areas of his practice. The panel was of the opinion that "the identified deficiencies in your performance, your lack of sufficient insight into them, and your failure adequately to address them, could potentially put patient safety at risk". The lawyer for the GMC, on the recommendation of the GMC's performance assessors, sought erasure. The panel, after considering mitigating factors, decided that Mr. B could continue to practise, subject to conditions over the next 18 months. The conditions, I would say, were procedural and undemanding, with no objective assessment of competence required. Before the period was up there would be another review hearing.

15. Dr C, a general practitioner, first appeared before the GMC in 2008. A performance assessment had demonstrated seriously deficient performance and there were also performance and conduct issues arising from his work with a deputizing service. Conditions which allowed him to continue in practice were placed on his practice for 12 months. A review of his performance a year later concluded that his practice—under the supervision of a GP trainer, was still impaired—so conditions were continued. Prior to the current hearing he had a further reassessment. The panel heard that there was a "stark difference" between the results of the objective competence /performance assessments and the reports of workplace supervisors. The GMC lawyer, reflecting the GMC assessors' conclusions, sought erasure. He noted that Dr C had already had significant re-training with only marginal improvement. "More conditional registration or suspension is unlikely to bring about the improvements required, and there is no realistic prospect that your performance will improve to an acceptable standard". In the event the panel decided to allow the doctor to continue in practice under conditions of an essentially managerial nature; it did require the doctor to submit to a further performance assessment before another review.

16. In each of these cases the GMC had sought erasure to protect patients from quite longstanding bad practice. In each one the "independent" panel, hearing pleas of mitigation from the doctor, appears to have been inclined to be "fair" to the doctor, inevitably at the expense of patients who have no voice at that point in a hearing. Furthermore, there is nothing on the GMC's website that I can find to indicate that it intends to appeal against these decisions in pursuit of its duty to protect patients and proper professional standards, as it is entitled to do today through the Council for the Regulation of Health Professions and which it will have the right to do itself in future. In each case patients will continue to be at risk; and there will be further, expensive reviews which could have been avoided with tougher decisions which put the needs of patients first.

17. I have sympathy for panel members. Of the corporate GMC, they are nevertheless separated from it by "Chinese Walls" to protect their impartiality. They cannot be helped in their efforts to reach a sensible adjudication in individual cases when there are no clear, well-publicized boundaries within each specialty distinguishing between what is regarded as good and substandard clinical practice.

## 18. *Synthesis*

The first point to emphasise is that, with Good Medical Practice as the foundation guide, British university medical schools and the GMC have together set a high bar for entry to the medical profession. There is no argument about it. The profession and the GMC are proud of the standard, the public is content because it wants good doctors, and there is an ample supply of highly qualified and able people who want to be doctors.

19. It is the same case with the specialist training that follows. The medical royal colleges and the various specialist training organisations are thorough these days in making sure that doctors completing vocational training are deemed to have reached the very good standard of competence and conduct they consider is necessary to practise as consultants or principals in general practice. The standards they require, and the high bar they set, are such that anyone can have confidence in the practice of a newly certificated UK trained doctor.

20. The problems really begin with established doctors. It is important to understand why. Historically the standard of practice followed by doctors throughout the remainder of their careers has been and still is down to individual conscience in the exercise of professional autonomy, with the onus on the GMC to prove that a doctor may be in breach. The well documented consequence is that for over a century the generally good

standing of doctors with the public has tended to obscure the fact that the profession, perversely, has been remarkably tolerant of poor practice from a minority of its members, and therefore inclined to be protective of all but the most flagrant offenders through a misplaced sense of collegiality and dated ideas of professional autonomy. Until the 1990's, with no clear guidance from the GMC or the royal colleges, it was left to individual GMC fitness to practise panels, lawyers and sometimes courts to make decisions about the standard of medical practice in individual cases. The arrival of Good Medical Practice in 1995 provided clear content boundaries and therefore improved panel decision-making and the quality of judicial appeals. In the 2008 the RCGP publication Good Medical Practice for General Practitioners (3) distinguished between exemplary and unacceptable criteria for revalidation, which was a step forward. Nevertheless, the GMC has never said where the bar should be for use by panels hearing fitness to practise cases, despite the persistent efforts of some of us to get it to do so.

21. Not surprisingly, therefore, some doctors are allowed to continue to practise, possibly with conditions, at a level *well below* that required by the GMC, the universities, the medical royal colleges and specialist societies to get onto the medical register and qualify as a specialist or principal in general practice in the first place. The cases in paras 13–15 above make the point. Were the public to be made fully aware of the situation they might think it almost unbelievable as well as unacceptable. Yet, the fact of the matter is that some panels, with arguments about mitigation before them, incline to give the doctor rather than the doctor's patients the benefit of the doubt. In practical terms, particularly in cases involving a doctor's competence and/or performance, this translates into unprotected patients and repeated expensive hearings as panels, anxious to be fair to a doctor, refuse to bite the bullet and remove serial underperformers from the profession. These are not rare happenings. I suspect that the cases I described earlier are just the tip of an iceberg. It would be helpful if the GMC would publish data and analysis regularly so that everyone could see the complete picture.

22. Almost inevitably, this unsatisfactory situation will be highlighted when revalidation is introduced, when the responsibility passes to the doctor regularly to demonstrate continuing fitness to practise to a "good" standard. But here is the rub. In cases of doubt, it is the GMC's Fitness to Practise Procedures and panels, operating today with a low, ill-defined bar, which will be used to underpin revalidation, to make the final decision about a doctor's future in cases where the revalidation screen has identified a problem which cannot be resolved at the workplace. So, working backwards, all involved in the various stages of revalidation will know this, and so have little incentive to address performance issues seriously. This is the Achilles heel of the whole revalidation/fitness to practise project as things currently stand.

23. In 2003 I explained the problem of the very low standard used by some panels to the Shipman Inquiry. At the Inquiry Sir Graeme Catto, then GMC President, described the standard prevailing generally in performance cases as "remarkably low". In her final report Dame Janet Smith said that "the reality of the "remarkably low" standard above which doctors will be revalidated does not square with the claim that revalidation gives an assurance that the doctor is "up to date and fit to practise"" (4). Now, nearly eight years on, nothing seems to have changed. This is why urgent action is required.

24. If this is not fixed, public disillusion and anger will follow, as sure as night follows day, when some recently revalidated doctors are shown subsequently to be performing badly, almost certainly as a result of a patient complaint. One sees this today where an institutional regulator has signed off a hospital or care home as providing good care shortly before a complainant, whistleblower or press investigation shows that this is not true.

#### 25. *Leadership from Cardiac Surgery*

There is a way forward. I commend to the Committee the lead given to the medical profession by the Society of Cardiothoracic Surgery of Great Britain and Ireland (SCTS) in resolving the problem in their specialty. The Society has taken responsibility for and ownership of the clinical and professional standards they expect of every UK cardiac surgeon (5). They settled the bar issue by saying that:

*"The Society believes that every single patient should always receive the best possible care from every surgeon undertaking cardiothoracic surgery"*

The bar they use reflects the contemporary standard of knowledge, clinical skill and performance that consultant cardiac surgeons should achieve under normal operational circumstances. They know what this is because every operation done by every UK cardiac surgeon in the NHS is benchmarked against peers in the UK. Furthermore, they are committed to transparency through the published results of individual surgeons. They are proud of their standard. It is the standard they will offer for revalidation. I hope that the members of the Health Select Committee will consider their recent report carefully—and talk to them—because they describe principles and a template, capable of being adapted and applied across the whole of medical practice.

26. When royal colleges and specialist societies take this kind of initiative, the GMC must be prepared to recognise such standards and make full use of them in revalidation and fitness to practise. How else would the GMC know what the specialty specific standard should be appropriate to doctors' chosen field of practice and level of clinical responsibility in their everyday work?

#### 27. A "To Do" List

With revalidation coming, it is important to think of fitness to practise and revalidation as a whole system starting at the workplace, where continuous quality improvement and quality assurance are well and truly grounded in regular, high quality feedback on performance and effective clinical governance. The annual appraisal, rigorously carried out against a baseline specialty—specific standard and grounded on robust evidence of competence and performance, should provide the foundation for maintaining a good standard of practice and for spotting and acting on problems quickly. This is the right place for “consensual” discussion and prompt remediation. It is the right place for the colleges to apply peer pressure on underperforming colleagues, to get them to improve and change their practice where this seems to be necessary. We know that conscientious doctors with a problem of which they may be innocently unaware will respond willingly and effectively. Therefore, assuming that the system works as intended, performance cases which have to be referred to the GMC in future should be limited to those doctors who will not take responsibility for maintaining a good standard of practice, who will not change their behaviour, and who are therefore by their own hand already raising doubts about their suitability to remain in the profession. Other than in some cases of ill health, it is their decision to underperform, or to perform or behave badly. It follows that they have to accept that there will be consequences which are self-inflicted.

28. Given that context, the following need to happen:

- (a) Start revalidation across the whole of the profession in 2012. There must be no phasing, with the most risky categories of doctor left until last.
- (b) The GMC needs to tell the public, in plain language, what Good Medical Practice should mean for them. Patients and relatives need a clear, readily accessible benchmark against which they can judge the performance of their doctors.
- (c) Decide that the bar for generic professional standards for use in revalidation and fitness to practise must be no lower than that already required for obtaining licensure in the first place, on qualifying from a British medical school.
- (d) Ask the royal colleges and specialist societies to determine the expert clinical standards expected of consultants and principals in general practice. Decide that the bar for use in the revalidation and fitness to practise proceedings for these doctors must never be lower than that required by the royal colleges and training authorities for entry to the doctor’s chosen specialty, and ideally should be titrated closely to the content of the doctors work and the level of responsibility involved. Ask the GMC to recognise, endorse and make full use of those standards and the bar where they indicate “good” practice in that field.
- (e) Tell the profession and the public where the bar is so that everyone knows what is expected.
- (f) The current legal definition of “deficient performance” is circular. The GMC needs to publish an explanation on its website, again in plain language that everyone can understand, of exactly what that definition means.
- (g) In particular, support appraisers and Responsible Officers by telling them where the bar is when making revalidation recommendations.
- (h) Make sure that members of the Council of the GMC take ownership of the standards, that they understand and accept that they are responsible individually and collectively to Parliament and the public for ensuring their sufficiency, and that the regulatory system works effectively to make certain that such standards are properly observed.
- (i) Make it clear to doctors that, once qualified, they have no natural entitlement to retain their license to practise unless they continue to observe the standards of the profession conscientiously.
- (j) Ask the Council of the GMC to make it clear to all involved in operating revalidation and fitness to practise procedures on its behalf, that the standards it sets in Good Medical Practice, and the level of the bar it deems appropriate to fulfill its responsibilities under the Medical Act, must be rigorously reflected in all fitness to practise decisions.
- (k) When a panel finds against a GMC decision to recommend erasure, expect the GMC automatically to appeal against the decision on behalf of the public, just as a doctor can appeal a panel decision should he/she decide to do so. This way the Council will demonstrate in a very public way that it is serious about protecting patients and upholding the profession’s standards.
- (l) Publish regular analyses of fitness to practise cases, every year, in a way that enables everyone to see that the GMC’s standards are being rigorously observed.

29. *Finally*

I have written here about a general principle which should apply to the regulation of all the health professions.

30. *References*

- (1) General Medical Council. Good Medical Practice. Fourth Edition. London: GMC; 2006.
- (2) House of Commons Health Committee. Revalidation of doctors. Fourth Report of Session 2010–11. February 2011.

(3) Royal College of General Practitioners. Good Medical Practice for General Practitioners. London: RCGP; 2008.

(4) The Shipman Inquiry. Safeguarding patients: lessons from the past, proposals for the future. London: Stationery Office, 2004. See Para26.149 and Para26.181.

(5) Society for Cardiothoracic Surgery in Great Britain and Ireland. Maintaining patients' trust; modern medical professionalism 2011. London: SCTS; 2011. Available at [www.scts.org](http://www.scts.org)

June 2011

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### **Written evidence from the Academy of Medical Royal Colleges (GMC 04)**

#### Introduction

1. The Academy of Medical Royal Colleges welcomes the opportunity to make comments to the Committee for its forthcoming scrutiny of the GMC. Recognising the nature of this scrutiny, this is a brief submission highlighting some key issues around

- The GMC/PMETB merger
- Revalidation
- Fitness to Practice standards
- Regulation of tele-medicine

which we hope will be of interest and assistance in your scrutiny.

#### ACADEMY OF MEDICAL ROYAL COLLEGES

2. The Academy's membership comprises the Medical Royal Colleges and Faculties across the UK. The Academy's role is to promote, facilitate and where appropriate co-ordinate the work of the Medical Royal Colleges and their Faculties for the benefit of patients and healthcare. The primary interests of Colleges and Faculties are postgraduate medical education and standards of clinical practice but they also have a general interest in healthcare policy.

3. The Academy works particularly closely with the GMC over the development and introduction of revalidation and on issues relating to post-graduate medical education. Whilst both organisations quite properly have their own perspectives and priorities on specific issues, we believe that we work together in a constructive and positive manner. We hold a regular senior level liaison meeting and both organisations involve the other in relevant Committees. We welcome the positive approach the GMC takes to involve the Academy and Medical Royal Colleges on appropriate issues.

#### GMC/PMETB MERGER

4. The Academy was supportive of responsibility for undergraduate, postgraduate and continuing education being brought together in the GMC. The Academy would wish to commend the GMC on the handling of the merger with PMETB. The general view is that the merger has been handled smoothly and efficiently and Colleges feel, albeit not unanimously, that the work is being handled effectively. The relationship between Colleges and PMETB was not always positive although it had improved in recent years. The Academy believes there is a strong case for greater College representation on the GMC's Post Graduate Board but is optimistic that there will be a positive and constructive engagement with the GMC on issues relating to post-graduate medical education.

#### REVALIDATION

5. The whole process of the development of revalidation has been slower and rather more tortuous than anyone would have liked, as we reported to the Select Committee's 2011 Inquiry "Revalidation of Doctors". The Academy has felt that at times there has been insufficient overall clarity and direction in the whole process. We have, however, worked closely with the GMC and continue to do so. Currently the Academy is developing the specialty specific aspects of guidance for doctors undergoing revalidation and is liaising closely with the GMC.

#### STANDARDS FOR FITNESS TO PRACTISE

6. The Academy is aware that the GMC has been reviewing its fitness to practise processes and is also reviewing Good Medical Practice. We have not responded to the fitness to practise consultation although a number of individual members have done.

7. We did write to the GMC on the general point of the need to ensure that doctors' performance is judged against the appropriate standards. Revalidation rightly requires assurance of a doctor's competence in the fields within which they are actually practising. Similarly we believe that fitness to practise procedures must ensure

that the relevant doctors perform to the standards of specialty practise described by the Colleges, as well as meeting the general requirements of Good Medical Practice.

8. The Academy thought it might be helpful to the Committee to place this on record and to state our clear belief that, as the safety of patients must be the paramount consideration in any changes to fitness to practise procedures, doctors who are proven to be unable to meet the required standards of practise and/or conduct should not be able to continue to hold a GMC licence to practise.

#### REGULATION OF TELE-MEDICINE

9. The Academy has real concerns over the issue of the regulation of tele-medicine and professionals undertaking tele-medicine which the Committee may wish to explore with both the GMC and CQC.

10. Doctors based out-with the UK do not come under the regulations of the GMC even if they are making decisions on the management of UK patients.

11. We have discussed this issue with both the GMC and CQC. Both organisations are very understanding of the problem but bound within their legislative framework and this is a case where legislation has been overtaken by technological change.

12. A short brief on the issue prepared by the Royal College of Radiologists is attached and the Academy would welcome the support of the Committee in ensuring that UK patients do not suffer a two-tier system of regulation.

*June 2011*

### Annex A

#### TELEMEDICINE AND THE REGULATION OF DOCTORS CURRENT ISSUES AND RECOMMENDED SOLUTIONS

##### TELEMEDICINE

As a result of technological developments, medicine can now be increasingly practised by doctors who are geographically remote from the patient. Examples include:

- the interpretation of imaging investigations (Teleradiology),
- e-prescribing (Teleprescribing),
- investigation of tissue samples and biopsies (Telepathology)
- e-monitor patients with chronic diseases (Telemonitoring)

The use of remote robotic surgery is the subject of on-going research.

All these involve a doctor practising their medical skills on patients remotely, in other words “practising medicine”.

##### ISSUE

1. Telemedicine is increasingly being used to treat UK patients by doctors located outside the UK. UK patients have the right to expect that all doctors involved in their care will be regulated to the same standard, and that in the case of substandard care, patients will have the right of redress. This would involve action either in the UK legal system, or referral to the doctor’s regulator, so that their fitness to practise may be assessed. If the doctor is not regulated by the General Medical Council (GMC), such regulatory referral would have to be made to the doctor’s regulatory body in another country, with standards which may differ from those of the GMC, and where complaints systems may be completely different, and in a different language. This is neither practical nor reasonable.

2. Doctors located outside the UK who practise remotely on UK patients are not currently subject to the same standards of and requirements for regulation as doctors located within the UK, and the patients may not have the same rights to redress.

3. The GMC website states that in order to practise medicine in the UK doctors need to be regulated and have a licence to practise with the GMC. The GMC’s current legal interpretation of this is that it only applies to the location of the doctor, not the patient in question. Therefore, at present, doctors located outside the UK who practise on UK patients are not required to be registered, or hold a licence to practise, with the GMC. Only doctors who have a licence to practise with the GMC will be required to revalidate to show every five years that they remain fit to practise. Therefore doctors who are not registered or licensed with the GMC will not be required to undergo revalidation, nor would doctors registered with the GMC but without a licence to practise. Therefore, only doctors licensed with the GMC will be regularly reviewed to ensure that their professional standards are maintained.

4. This is leading to two tier system. For example, a teleradiology company reporting images of UK patients may use GMC-licensed UK-based radiologists some of the time, and offshore GMC-unlicensed radiologists at

other times. Thus, whether the UK based patient has a right to redress, in terms of holding the doctor to account for their fitness to practise, may depend on which day of the week their images were reported.

5. The Academy of Medical Royal Colleges has discussed this topic with the GMC, and brought it to the attention of the Department of Health (DH) and Care Quality Commission (CQC). The GMC has acknowledged that this needs to be addressed but will require changes to primary legislation.

#### RECOMMENDATIONS FOR CHANGE

##### *Short term*

1. *GMC*—The GMC is currently reviewing its publication *Good Medical Practice (GMP)*. We consider the next edition of *GMP* should state that patients who are being cared for in the UK should be able to rely on the same standards of and requirements for regulation by a doctor, and have the same right to redress, irrespective of whether that doctor is located within or outside the UK. All doctors involved in the care of UK patients should also be subject to the same requirements for the regular review of their practice.

2. *CQC*—The CQC should require any doctor providing medical services to patients in the UK to hold a licence to practise with the GMC as a contractual condition.

##### *Long term*

3. The DH should enable the GMC to regulate all doctors who practise on UK patients through legislative change. We believe this will require an amendment to the Medical Act (1983).

June 2011

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### Written evidence from the Medical Protection Society (GMC 05)

#### INTRODUCTION

1. The Medical Protection Society (MPS) is the leading provider of comprehensive professional indemnity and expert advice to more than 270,000 doctors, dentists and other health professionals around the world. We have nearly 120 years experience of the medicolegal environment and operate in 40 countries around the world. In the United Kingdom we have around 170,000 doctors, dentists and other healthcare professionals in membership comprising around 50% of all doctors and 70% of all dentists.

2. As a mutual, not-for-profit organisation we offer members help, on a discretionary basis, with legal and ethical problems that arise from their professional practice. This includes clinical negligence claims, disciplinary and professional regulatory investigations, inquests, complaints and general ethical and professional advice.

3. MPS welcomes the Health Select Committee's decision to strengthen its relationship with the General Medical Council (GMC) and to take on the scrutiny function once carried out by the Privy Council. We have extensive experience of working with the GMC when representing our members who are the subject of complaint or investigation. In addition, we are often in contact with the GMC through meetings to facilitate improving investigation and adjudication processes; dealing with matters relevant to student fitness to practise procedures and registration of students; and in providing responses to their consultation papers.

4. MPS generally has a good working relationship with the GMC. However we have some concerns about the GMC's recent proposals for fundamental changes to its fitness to practise and adjudication procedures for doctors. We have long held concerns about the fairness, efficiency and proportionality of fitness to practise hearings and although these proposals go some way to address them we believe the plans need to be reshaped to strike the right balance for doctors, patients and the public.

#### KEY ISSUES

##### *Reform of fitness to practise procedures*

5. The GMC is exploring how fitness to practise issues can be resolved through better dialogue with doctors, rather than through public hearings, which can be stressful, drawn out and costly. We support this proportionate approach and are encouraged by the GMC's explicit focus on doctors' current and future fitness to practise, rather than on punitive measures for past misconduct.

6. However, we do have concerns about lack of detail and whether the correct issues were covered by the consultation process. We question whether any system outside the formality of a panel setting is realistically capable of dealing efficiently with the facts in the very large cases—the ones which are so costly.

7. Although these proposals appear largely pragmatic, whether they deliver on their aspirations to achieve swifter and more efficient resolution, will depend on a number of factors, such as ensuring there are high quality investigations, having the right people and expertise and offering realistic sanctions. The current fitness

to practise system encourages an adversarial approach and MPS believes a fundamental shift will be needed by all parties if the proposed reforms are to succeed.

8. Moreover the success of this scheme will depend on whether it holds the public's confidence. A robust strategy for communicating with and securing the public's support will therefore be needed.

#### *Reform of adjudication*

9. The GMC is also consulting on plans to create a new tribunal service for fitness to practise adjudication, which would take responsibility for administering hearings and for panel decisions. In principle we are strongly supportive of this proposal, as long as it is truly independent and there is a clear and genuine separation between the respective roles and function of the new tribunal service and the GMC.

10. However we are seriously concerned about the GMC's proposal to move to a single hearing centre in Manchester as this would place a huge and unnecessary burden and inconvenience on some doctors (who will be personally responsible for the costs they incur in travel and accommodation) and witnesses. The cost and convenience to the GMC seems to be the overriding reason for the proposal and while MPS recognises that cost should be and is an important factor, particularly in the current financial climate, it should not be the overriding factor that dictates the venue of all hearings. In criminal and civil court settings, it is convenience which is deemed the primary consideration and we believe this is the correct approach to take. Whilst the GMC's cost arguments may appear persuasive, we believe there is considerable scope for efficiencies in the overall management of fitness to practise cases, which should be addressed before such a drastic step is taken.

11. We also consider the proposal by the GMC to create a second right of appeal against adjudication decisions is grossly unfair to doctors, given the existing power of the Council for Healthcare Regulatory Excellence, in challenging decisions which it considers too lenient. It is a form of double jeopardy for a doctor to have the outcome of his or her hearing potentially challenged not once, but twice by two separate bodies—as the courts have recently commented, it is important for there to be finality.

12. MPS will continue to monitor the GMC's proposals with interest and looks forward to working with the GMC to shape the reforms.

13. MPS's responses to the recent GMC consultations can be viewed here: <http://www.medicalprotection.org/uk/news-and-press/policy-and-response-documents>

June 2011

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### **Written evidence from Healthcare Audit Consultants Ltd (GMC 06)**

#### Summary

In general there is no quarrel with the existing legal framework under which the GMC operates although clarification is needed to support what we would recommend as a more active stance from the regulator and a move away from light-touch regulation.

This clarification should require the GMC to:

- act to ensure there is an adequate supply of appropriately qualified and trained staff to meet the needs of the healthcare sector in the UK (including the private sector) and to make a contribution to the needs of other countries.
- do more to clarify and foster best practice, promote guidelines and cut out old-fashioned ways that may harm the patient.
- focus on fairness, inequality and diversity so as to assist in dealing with health inequalities.
- liaise and co-operate with other regulatory, audit and management bodies. Its terms of reference should include a duty to co-operate.

Thus, we recommend that:

1. the GMC takes a more proactive role in promoting an adequate supply of doctors in the UK.
2. the GMC periodically reviews the adequacy of the numbers and quality of those on the medical register and make recommendations to those that set the numbers of medical training places and determine curricula and training regimes.
3. the GMC institutes a more formal recording of contact time during training periods which may make it easier to identify inappropriate behaviour.
4. the GMC considers how best the consultant body is regulated to prevent consultants and their teams undertaking caseload when they do not have the requisite training and experience or back-up teams and where a referral to a specialist centre would be more appropriate.
5. the GMC reinforces barriers to inappropriate medical intervention, promotes review of cases of adverse outcomes caused by late referral, and considers sanctions if necessary.

6. the GMC issues guidelines and productivity norms based on case-mix that could be available for peer review and medical management purposes.

7. the GMC establishes a proactive audit and intervention service that can be called in by clinical directors and chief executives when faced by issues of concern.

8. the GMC provides a positive lead toward more collaborative working in larger clinical networks.

9. the GMC issues guidelines to foster better practice for both high risk patients and in long term condition management.

10. the GMC in its role of fostering best practice, along with the Royal Colleges, considers whether there are risks to the accessibility of services to patients in major reorganisations and provides further support to staff to work more flexibly over more local sites.

11. the GMC regularly monitors the inequality in both outcomes and inputs into healthcare and considers more active interventions in this field.

12. the GMC reviews the clinical audit function within providers to consider how performance can be improved.

13. the GMC in its role of regulator of clinical practice reconsiders the proportionality of its responses in the light of continuing problems in the delivery of healthcare and whether it needs to clarify standards, monitor performance, target where there are areas of concern and be seen and accountable for taking action.

14. the GMC reviews its governance and management structure after further consideration by Parliament and government on the role expected of the GMC.

15. the GMC liaises and co-operates with other regulatory, audit and management bodies.

16. there is a review of the period of medical training to cope with new demands made of doctors.

17. the budgets of all regulators are reviewed in relation to each other and the reduction of strategic management in the NHS generally.

## 1 INTRODUCTION

1. Our perspective is as independent advisors on healthcare issues experienced in a wide range of healthcare matters. As far as this consultation is concerned we have sought to look at the bigger picture and ask whether the current terms of reference of the GMC address the many problems and issues in the UK healthcare system and whether changes to the terms of reference are appropriate. At the same time we have then considered how well the GMC is discharging its current functions and have provided some recommendations.

## 2 GMC TERMS OF REFERENCE AND PERFORMANCE

2. The law gives four main functions for the GMC under the Medical Act 1983:

- Keeping up to date registers of qualified doctors
- Fostering good medical practice
- Promoting high standards of medical education and training
- Dealing firmly and fairly with doctors whose fitness to practice is in doubt.

We consider each of these main functions and the GMC's performance.

## NUMBERS OF DOCTORS ON THE REGISTER

3. The GMC controls entry to the medical register and sets standards for education and training. It therefore plays a large role in controlling the supply of medical staff. There are considerably fewer medical staff employed per 1000 population in the UK compared to other advanced western countries and there are difficulties in enrolling on medical training courses with demand far outstripping the supply of places available.

	<i>UK</i>	<i>France</i>	<i>Germany</i>
Number of Practising Physicians per 1000 population	2.5	3.4	3.5

Source: *OECD Database 2009*

4. We believe the supply of medical staff has been artificially constrained and we *recommend* that the GMC is encouraged to take a more proactive role in promoting an adequate supply of doctors in the UK. We acknowledge the GMC does not control the number of training places but believe that the GMC should play a more proactive role in ensuring an adequate number of medical staff to meet needs. We note "Liberating the NHS: Developing the Healthcare workforce" proposed that Health Education England (HEE) should take a lead in training and education; we *recommend* the GMC along with the Royal Colleges is more involved. The GMC has in our view contributed to the restriction in the numbers of doctors in the country by accepting the

numbers entering training and by not supporting would be immigrant doctors sufficiently. At one time overseas doctors on postgraduate courses were prevented from completing periods of studies because of difficulties with visas. Also medically-qualified refugees in this country have been forced to take other work because there was limited assistance to obtain suitable employment in the UK. The GMC may have been in a good position to help resolve these difficulties and thus improve the supply of suitably qualified doctors in the country.

5. Although the medical profession may resist, we believe the population would be better served with more, less well-paid doctors rather than fewer, overstretched doctors. The current arrangements for determining doctor numbers are opaque<sup>16</sup> and although numbers in training have increased it is not clear whether the numbers in training will be sufficient to meet future needs.

6. We *recommend* that the GMC periodically review the adequacy of the numbers and quality of those on the medical register and make recommendations to those that set the numbers of medical training places and determine curricula and training regimes.

## STANDARDS

7. We believe there is evidence of inadequate supervision of junior doctors.

8. The following is a quote from the BMJ in November 2010:

“Many foundation year doctors are being asked to practice beyond their level of competence and with inadequate supervision, according to a report from Medical Education England.

The report *Foundation for Excellence* by John Collins, visiting professor in the Nuffield Department of Surgery at the University of Oxford, is a detailed evaluation of the foundation programme in the United Kingdom based on extensive written and oral evidence, which included a review of nearly 300 relevant publications.

While arguing that the foundation programme should largely remain in its current form, the report highlighted problems with its design, content, safety, and quality.

Among the report’s key recommendations were that the length of the programme should be reviewed in 2015, and that the issue of student registration with the General Medical Council should be revisited.

It also questions the appropriateness of placements, which focus predominantly on adult secondary care, when the government aims for 55% of foundation doctors to enter primary care. It recommends keeping placement lengths at between four and six months.

Christopher Edwards, chairman of Medical Education England, was concerned by patient safety issues raised by the report. “It is clear from the evidence [Professor Collins] heard, and from other recent respected and credible sources of evidence, that, in some cases, trainees are not being adequately supervised, and there is a clear patient safety issue that needs to be addressed,” he said.

His views were also echoed by the BMA. Tom Dolphin, co-chair of the BMA’s Junior Doctors Committee, said that instead of the foundation programme being an exciting launch pad for their careers, many junior doctors “are finding that the first two years of training are characterised by inadequate levels of supervision.”

“We also need to urgently investigate problems with the selection of doctors into the programme, the length of work placements, and the excessive levels of assessment,” he said.”

9. Our audit experience bears this out with problems being caused in the accurate coding of patient notes because of poor levels of supervision.

10. We *recommend* that consideration be given to a more formal recording of contact time during training periods which may make it easier to identify inappropriate behaviour.

## FOSTERING GOOD MEDICAL PRACTICE

11. One of the problems in the UK is that the clinical freedom of a qualified consultant practitioner is, we understand, much more extensive in the UK than elsewhere where there are more controls on the case-mix that a consultant can undertake. We have encountered in the UK examples of heroic interventions by consultants in situations where the local level of resources and experience did not merit the risks being taken. There has been controversy over the years in consolidating areas of specialist medicine e.g. cleft lip surgery.

12. We *recommend* that the GMC should consider how best the consultant body is regulated to prevent caseload being undertaken where the consultant and teams will have not received the requisite training and experience or have the back-up teams with resources and a referral to a specialist centre would be more appropriate. The regulation should be biased towards prevention of high risks being taken rather than advice and review. Financial incentives are such within a hospital that there is a reluctance to refer cases to tertiary centres; to combat this, we *recommend* the GMC reinforce barriers to inappropriate medical intervention, promote review of cases of adverse outcomes caused by late referral, and consider sanctions if necessary.

<sup>16</sup> See *Liberating the NHS : Developing the Healthcare workforce* July 2010

13. It is not clear that the GMC is proactively fostering good practice on NHS productivity where the NHS does not perform well.

14. The Kings Fund report *Improving Productivity* (July 2010) concluded:

“Many of the most significant opportunities to improve productivity will come from focusing on clinical decision-making and reducing variations in clinical practice across the NHS. Reducing variations in clinical service delivery (as highlighted by the Better Care, Better Value Indicators) and improving safety and quality should be key priorities for providers. There is also an opportunity to improve the prescribing and management of drugs, which account for 12 per cent of the overall NHS budget”.

15. There has been controversy over the years around productivity in theatres and in the NHS generally to justify the massive investment provided in recent years. There are examples of manipulation of productivity to maintain waiting lists in orthopaedic surgery in the past—where the recruitment of additional staff has resulted in compensating reductions in productivity (e.g. the work of John Yates focussing on waiting list initiatives in the early 2000s). Although there may be good reasons for differences in productivity we *recommend* the GMC should issue guidelines and productivity norms based on case-mix that could be available for peer review and medical management purposes. We further *recommend* the GMC consider establishing a proactive audit and intervention service that can be called in by clinical directors and chief executives when faced by issues of concern.

16. In addition productivity can be poor in small units. In these circumstances there should be a presumption that co-operation will be given to working in larger networks where cover, case mix and skills can be better managed. Unfortunately we have experienced lack of co-operation and outright hostility to moves to manage scarce resources better e.g. Pathology modernisation, based on the self-interest of staff that may be asked to work more flexibly.

17. We *recommend* the GMC provides more of a lead toward more collaborative working in larger clinical networks. Without this pressure there are grave risks of increased fracturing of services leading to inappropriate clinical risk taking and impact on quality and safety.

18. The NHS is criticised for its inability to identify high-risk patients and to ensure early diagnosis of common conditions. The population still presents cases too late for timely diagnosis and early treatment often to the detriment of the patient and to the costs of the NHS.

19. Promotion of services to patients with chronic conditions remains a weakness in the NHS with doctors still adopting a repair service and last ditch intervention service rather than a timely, proactive and monitoring role using new technology and close links with other professionals to identify patients in need. We therefore *recommend* the GMC consider issuing more guidelines to foster better practice for both high risk patients and in long term condition management

20. In addition there is a trend towards establishing ever larger hospitals for common treatments as a way to address the NHS’s financial problems. While we accept the need for concentration of complex work so that staff deals with sufficient volumes and are supported by adequate back up, there is a case for outpatient, day case and diagnostic consultations to be locally provided in smaller units. For example the centralisation of obstetrics seems to be driven by staff inflexibility in dealing with the European working time directive rather than the needs of patients for accessible services. We therefore *recommend* that in its role of fostering best practice that the GMC along with the Royal Colleges consider whether there are risks to the accessibility of services to patients in major reorganisations and provide further support to staff to work more flexibly over more local sites.

#### PROMOTING FAIRNESS AND EQUALITY AND VALUES DIVERSITY

21. Healthcare in the UK has become more unequal in recent years with the gap between those with improving health and others growing. GPs and health resources are still distributed unequally despite years of “redistribution”. This may become worse in future years. It is not clear what role the GMC has taken to prevent this.

22. We *recommend* the GMC regularly monitor the inequality in both outcomes and inputs into healthcare and consider more active interventions in this field.

#### DEALING FIRMLY AND FAIRLY WITH DOCTORS WHOSE FITNESS TO PRACTICE IS IN DOUBT

23. This is where the focus of GMC activity has been in the past. We believe that support and intervention should be earlier. We find that there is little evidence of a proactive audit of clinical performance with anecdotal evidence that a great deal of clinical audit activity is perfunctory and inconsequential. We *recommend* that the GMC review the clinical audit function within providers to consider how performance can be improved.

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RESPECTING THE PRINCIPLES OF GOOD REGULATION: PROPORTIONALITY, ACCOUNTABILITY, CONSISTENCY, TRANSPARENCY AND TARGETING

24. We argue the GMC has erred on the side of light-touch regulation in the face of ample evidence to justify a more rigorous approach. The climate within the profession may not wish for more regulation but UK performance does not justify complacency.

25. In addition we believe that too often it appears that the NHS acts to cover up problems and to avoid repercussions rather than be open, encourage self-criticism, to learn from mistakes and compensate adequately when mistakes cause harm. Whistleblowers have not been handled well with many feeling victimised. Foundation Trusts are becoming less transparent and less open to local authority scrutiny.

26. The GMC has not taken an active role to prevent this. When confronted by major scandals e.g. Mid-Staffs and Bristol, the GMC has not acted in a timely way to prevent or deal with such events. The question therefore remains whether the GMC's terms of reference as a regulator of medical issues in the NHS are adequate.

27. We *recommend* that the GMC in its role of regulator of clinical practice reconsiders the proportionality of its responses in the light of continuing problems in the delivery of healthcare and whether it needs to clarify standards, monitor performance, target where there are areas of concern and be seen to be accountable for taking action.

28. The GMC must have the resources to do the job. Monitor and other public sector regulators have substantial budgets to enable their jobs to be discharged. We *recommend* that the budgets of all regulators are reviewed in relation to each other and the reduction of strategic management in the NHS generally. We would regard it as anomalous if the economic regulator had a budget out of proportion to the clinical regulator.

29. We *recommend* a review of the governance and management structure of the GMC after further consideration by Parliament and government on the role expected of the GMC. We would currently consider the GMC as passive and under resourced to manage adequately its responsibilities.

30. We *recommend* the GMC must liaise and co-operate with other regulatory, audit and management bodies. Its terms of reference should include a duty to co-operate.

June 2011

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**Written evidence from the Royal College of Surgeons (GMC 07)**

1. The Royal College of Surgeons welcomes the Health Select Committee's evidence session on the work of the General Medical Council (GMC). The GMC is currently accountable to Parliament through the Privy Council. We believe that in the public interest the GMC should be held to account by the Health Select Committee as the Committee recommended in its recent report on "Revalidation of Doctors".

FITNESS TO PRACTICE AND REVALIDATION

2. We believe that the GMC's fitness to practice procedures are cumbersome and slow and should be simplified. We are pleased that the GMC is currently reviewing its fitness to practice processes and the standards to which doctors are held to account, which is published in *Good Medical Practice*. However we think that for consultant surgeons, assessment solely against the GMC standards is not enough. If a surgeon on the specialist register is under consideration as part of the fitness to practice processes, we think that they ought to be measured against the standards set out in the surgical curriculum.

3. Under the current plans for revalidation a specialist doctor will be required to demonstrate a "quality improvement activity" such as clinical audit or a review of clinical outcomes only once in a five year revalidation cycle. We do not think that this is adequate and will be issuing guidance that surgeons should undertake such activities every year. We would welcome affirmation from the GMC that doctors should follow College guidance and that fitness to practice panels would have regard to such guidance.

SURGICAL TRAINING

4. We are deeply concerned about the lack of detailed regulation of undergraduate medical education and would like to see a single syllabus and qualifying exam for all UK medical schools. This should be largely based on the requirements of employers for what the service needs from newly qualified doctors and on the requirements of Royal Colleges for what they need to train GPs and Specialists after their initial medical training.

5. The GMC scrutinises postgraduate curricula and examinations but quality assurance of training posts is based principally on an annual questionnaire/survey of trainees and trainers and deanery-wide visits. The College does not think that this is a sufficiently robust process and believes that only specialty specific visits and face to face interviews by independent professional groups such as Royal Colleges will ensure standards.

6. We believe that the Certificates confirming Eligibility for Specialist Registration (CESR), the route for those without a Certificate for the Completion of Training (CCT) who want to demonstrate that they have equivalent training and experience, should be revised. We note that the GMC is carrying out a high level review of the legislation and processes governing this route. The College has highlighted to the GMC that present procedures are inflexible and cumbersome. Furthermore the effects of the CESR process on UK medical workforce planning are not currently considered and should be in the future.

7. The Joint Committee on Surgical Training (JCST), which works on behalf of the four surgical colleges in the UK and Ireland, is responsible for developing and maintaining standards across surgical training. JCST evaluates when trainees are ready for the award of the CCT and makes recommendations to the GMC. It also evaluates CESR applications on behalf of the GMC and makes recommendations. Prior to 1 April 2010, these recommendations were made to the Postgraduate Medical Education and Training Board (PMETB) which has merged with the GMC. The GMC did not commit to change in the short-term, but it is now over a year since the merger and the RCS would be keen to find out the following from the GMC during the evidence session:

- Has the GMC made significant changes to PMETB's *modus operandi* and does it plan to introduce changes?
- Does it believe that there is scope to expand the role of the Colleges in areas such as quality assurance/quality management where the Colleges have expertise?
- Many of the areas for which the GMC now has statutory responsibility are underpinned by work that the Colleges do on an unremunerated basis. This includes curriculum development, the production of Annual Specialty Reports and all the work that goes into enrolling and monitoring trainees and making CCT recommendations when they complete their training. How sustainable is this business model in the longer term with increased pressure on clinician time?
- How does the GMC ensure that it receives appropriate specialist advice on registration and training matters?
- We have noted that it was PMETB's policy—and so far has continued to be the GMC's—not to involve surgeons in surgical curriculum panels. How are experts recruited to take part in curriculum or other panels? What is the rationale for not involving experts from the relevant speciality in certain types of panel?

#### MERGING THE GENERAL DENTAL COUNCIL WITH THE GMC

8. The College believes that consideration should be given to strengthening the relationship between the General Dental Council (GDC) and the GMC. The regulation of dentistry needs reform and sharing of best practice and processes with the GMC may help improve dental regulation. For example the current General Dental Council proposals for the revalidation of dentists are aimed at those working in primary care as general dental practitioners. Many dentists work within the hospital system (specialist and non-specialists) and will be exposed to the same appraisal systems (existing and enhanced for medical revalidation) as their medical colleagues. As such alignment with the medical model would be more appropriate. Increasingly dental surgeons also work in one of the dental specialties in a primary care setting as specialists and the medical model may be more appropriate for these specialists.

#### USE OF MEDICAL TITLES

9. The GMC should be prescriptive over the use of medical titles, for the protection of the public. The 1983 Medical Act must be amended to provide protection of the title consultant surgeon. For example "consultant surgeon" should be legally restricted to properly trained and accredited surgical specialists.<sup>17</sup>

June 2011

#### The Patients Association (GMC 08)

1. The Patients Association welcomes the opportunity to contribute to the scrutiny of the activities of the General Medical Council (GMC). The Patients Association is a national healthcare campaigning charity aiming to represent the interests of patients, working under the motto "listening to patients-speaking up for change."

2. An element of our submissions relates to the issue of revalidation, on which our views were previously outlined in more detail to the inquiry in its previous call for evidence on this matter. This submission is provided as an Appendix.<sup>18</sup> We believe this should remain the primary concern of the Committee in relation to improving the work of the GMC as regulator that not just address instances of poor practice, but that prevents poor practice from harming patients in the first place.

3. We welcome the decision taken to conduct these annual hearings and support them as an important tangible mechanism of accountability. We would ask the Committee to do what it can to encourage any future formations of the Committee to continue this approach in the next Parliament and in all those that follow.

<sup>17</sup> Surgical titles in the NHS—RCS position statement [http://www.rcseng.ac.uk/new\\_rcseng/content/publications/docs/surgical-titles-in-the-nhs-position-statement](http://www.rcseng.ac.uk/new_rcseng/content/publications/docs/surgical-titles-in-the-nhs-position-statement)

<sup>18</sup> <http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/557/557vw22.pdf> Ev w47

4. We would also seek to outline a number of additional points regarding the work of the GMC not considered in our submission on revalidation.

5. These are the current proposals for altering the process of fitness to practice (FTP) proceedings, information about the satisfaction of patients and the public with GMC decisions, awareness of the GMC and its function, appeal against FTP Panel decisions and registration of doctors from Europe.

#### CHANGES TO FITNESS TO PRACTICE PROCESSES

6. In a recent consultation the GMC announced proposals to reduce the number of FTP hearings through increasing the use of “consensual decision making”.

7. Although we acknowledge the GMCs statements that the purpose of these discussions or negotiations with doctors are not to introduce a system of “plea bargaining”, we are concerned as to the lack of detail around the agenda of these meetings, the aims and what these meetings are to achieve.

8. We are concerned that by using phrases such as “consensual approach” “practical facilitation” and “constructive discussions” the GMC is propagating the impression that the GMC has the doctors rather than the patients best interests at heart.

9. We do not feel that there has been sufficient articulation of the purpose of these meetings and strongly oppose them

10. After rejecting the request for voluntary erasure by Dr Al-Zayyat, the doctor in the Baby P case, the FTP panel chair Ralph Bergmann said: “The panel considers that to accede to the application for voluntary erasure would avoid a public, and necessary, examination of the facts.”

11. The Patients Association agrees with the sentiments of this statement. The default position should be that public examination of the facts is required so that patients have confidence that when the standards of the medical profession are not upheld, a thorough investigation is carried out and the necessary steps taken to protect the public.

12. It is not clear from the proposals what involvement patients and carers witnesses would have in these discussions. If the proposed changes reduce the use of FTP panels, by not including the patients and carers input at the discussion/meeting stage, the GMC is undermining their role in the FTP process. This reduces the ability of the GMC to ensure patients confidence in the profession.

13. The doctor will be able to react organically to discussions, whilst at best patient and carer witnesses will be able to contribute via statements. This would effectively create a disparity between the representations of all the parties giving evidence. This is not conducive to the GMC effectively discharging its duties to fairly and robustly investigate allegations of misconduct.

14. We believe oral hearings, whilst of course stressful for patients and carers, are immense value in tangibly demonstrating to the panel the impact of a doctors actions on individuals, which will be important in reaching any conclusion about the seriousness of any accusation of misconduct.

15. By testing evidence in public and having an open decision making process the public can have confidence that the decision made is based on evidence which they have heard.

16. Lay representation on FTP panels is a key mechanism of ensuring the voice of patients and the public is represented in the FTP process. If the number of FTP panels being held was reduced as a result of these proposals, that would mean an unacceptable reduction of this important mechanism of public involvement.

17. The GMC also propose to introduce “without prejudice disclosure” to enable doctors to reveal information that could then not be used as evidence during an FTP hearing We have serious concerns about this and the lack of transparency this brings to the already opaque nature of these proceedings. The fact that information shared will not be submitted at a subsequent hearing raises grave concerns regarding patient safety

18. If a doctor has failed to maintain standards of care in a number of incidences, and raises these in the meeting, are they then not to be discussed at the FTP hearing? How is this in line with the GMC’s role to protect patients?

19. Incidences involving patient safety should NEVER be part of a “without prejudice” discussion and as such be inadmissible as evidence to a FTP panel. This part of the proposal is unacceptable and further propagates the impression of a “closed door” policy whereby the GMC “looks after its own”—a common perception held by patients who phone our Helpline. All evidence needs to be made public.

#### INFORMATION ABOUT THE SATISFACTION OF PATIENTS AND THE PUBLIC WITH GMC DECISIONS

20. The GMC has informed us that it does not currently conduct regular surveys of those making referrals to the GMC to try and measure how satisfied they are with the decisions taken by the GMC, whether this be at the level of triage or at the conclusion of FTP hearings.

21. We understand they are seeking to implement such reviews in the future and would welcome any effort from the Committee to elucidate details and firm plans for these initiatives.

22. We would be particularly interested in understanding the views and concerns of those making initial referrals to the GMC in relation to their satisfaction with triage decisions.

#### AWARENESS OF THE GENERAL MEDICAL COUNCIL AND ITS FUNCTION

23. For the GMC to fulfil its functions effectively it requires referrals from third parties. Our concern is that there is a lack of awareness amongst patient and the public, both generally about the GMC and its role and more specifically when it would be appropriate to make a referral.

24. We would like to draw the Committee's attention to the remarks made by Sir Robert Francis during the ongoing Mid Staffordshire Public Inquiry in response to evidence being given by the Patients Association:

"It strikes me that information of the sort you suggest (information about how to complain and the role of professional regulators) could quite easily be incorporated with other information that gives rather mundane information about where to get out of the hospital...and where the canteen is."

25. We would encourage all those involved in regulation to think about how they might better inform patients and the public about their role and activities. Whilst perhaps not something you would expect every member of the public to be aware of, we feel that introducing at least the concepts of complaints and regulation (along with ways of finding out more) to those using healthcare services as a reasonable objective.

#### APPEAL AGAINST FTP PANEL DECISIONS

26. The FTP panels of the GMC are operated as independent bodies within the organisation that are required to consider the preference of the GMC (e.g. suspend, strike off), but to reach their views independently.

27. There were plans to separate these functions out into two new organisations but these have plans have been shelved by the Department of Health and the GMC is currently consulting on how it might move this agenda forward.

28. The Patients Association has not reached a detailed and settled view on this issue but would raise a concern about appeals of FTP decisions.

29. We are aware of a number of cases where the decision reached by the panel was not the one called for by the GMC. This may be appropriate, but we welcome scrutiny of how these occasions are considered particularly in relation to the appeal function of the Council for Healthcare Regulatory Excellence.

30. In its current consultation document the GMC states that "we believe that introducing a right of appeal for the GMC to the High Court or Court of Session in Scotland would reinforce the clear separation of investigation and adjudication work and help to create an independent identity for the MPTS."

31. We support this view.

#### THE REGISTRATION OF DOCTORS FROM EUROPE

32. We are concerned about the inherent assumption in the free movement of labour principles applied to EU healthcare professionals, that the training and regulation of such individuals is equivalent across Europe.

33. The Committee need only consider the journey that the training and regulation of doctors has taken in the UK alone over recent years to recognise that such an assumption should be considered with caution.

34. Take as an example the Shipman inquiry, a unique and unusual event that had profound implications for the regulation of doctors in the UK, and an event that occurred by chance as a result of what can only be considered an extremely rare instance of mass murder by a doctor.

35. The GMC has undergone considerable change in its own processes, introducing lay panel members and moving towards revalidation. That is the standard at which we regulate our own doctors. It would be useful to discuss with the GMC the extent to which they are confident that across Europe the regulation of doctors is sufficiently robust to give us confidence that all those arriving to practice medicine in this country have been subjected to at least the same level of scrutiny as doctors from the UK.

36. There is also the issue of language testing particular, though of course this could be considered a part of competence. In its submission to the European Commission Recognition of Professional Qualifications Directive Consultation states

"Currently, EEA applicants to the GMC register do not need to pass a language assessment even in cases where there is doubt. We have recent examples of EEA doctors seeking recognition and registration with the GMC who are not able to communicate in English and were assisted by an interpreter. This is a serious cause of concern to us."

37. We share this concern.

## Written evidence from the Office of the Health Professions Adjudicator (GMC 09)

### 1. SUMMARY

- This evidence is submitted by the Office of the Health Professions Adjudicator (OHPA) a body set up under the Health and Social Care Act 2008, but proposed for abolition within the current Health and Social Care Bill.
- Two of the principal responsibilities of these health profession regulators (GMC and NMC) are the bringing of proceedings against practitioners alleged to be unfit to practise, and the adjudication of such cases. OHPA was set up to perform the adjudication function, and to ensure that these two functions were kept separate so that there was no conflict of interest. These proceedings have also been widely criticised by patients for taking too long, and being too costly—both to the individual practitioners and to the NHS. OHPA had identified that many of the procedures had failed to keep pace with the reforms adopted in many other courts and tribunals, so we developed a programme to modernise these proceedings, thus reducing their cost and length.
- Given the intention of the Government to abolish OHPA, the GMC has developed a series of proposals to establish, so far as may be possible, a separate adjudication function as a tribunal within the structure of the GMC. It has also adopted, or proposes to adopt, much of the OHPA modernisation programme. Its proposals are largely to be welcomed.
- The NMC has so far taken no such steps. Both the Royal College of Nursing and UNISON, the union that represents many nurses, argued strongly that OHPA should not be abolished. This is an indication of unease within the nursing profession about the NMC's Fitness to Practise procedures. Given that nursing is by far the largest health profession, and that the potential impact of malpractice or incompetence on the part of nurses on public safety is as great as it is for doctors, this is regrettable.

### 2. BACKGROUND

2.1 The Office of the Health Professions Adjudicator was established under the Health and Social Care Act 2008. This was the result of a key recommendation of the inquiry by Dame Janet Smith into the serial killer doctor, Harold Shipman. Under the terms of the Act, OHPA would have taken over the adjudication of fitness to practise (FtP) cases brought by the GMC cases in April 2011, with the expectation that the other health and social care regulators (including the NMC) would have followed in due course. Once established, OHPA would have been self-financing, charging each of the regulators in remita fee. It would not have been a charge on the taxpayer.

2.2 The benefits of this approach would have included conspicuous independence and hence greater public confidence, consistency across the professions, and efficiency gains both from the introduction of modern tribunal practices and through economies of scale. However, the Government decided in December 2010 that it did not intend to proceed with the OHPA programme and clause 228 of the Health and Social Care Bill currently before Parliament would give effect to OHPA's abolition. Instead, the Government hopes to encourage all regulators to reform their own FtP practices.

2.3 Pending abolition, the OHPA board has continued to monitor developments in the field and to offer support and advice where this seems helpful. This is in line with what the Government said in its consultation report (*Fitness to practise adjudication for health professionals: Assessing different mechanisms for delivery*, November 2010): "The Government believes that once the GMC have their revised adjudication system in place, best practice can be shared with the other regulators. This will help create an environment for more consistent approaches and collaborative thinking. Key to this point is learning the lessons from OHPA. All those involved in the project recognise that the work of OHPA, its board, and its staff have expanded the debate about what a modern and efficient system of adjudication should look like and how it should operate." We have worked especially closely with the Council for Healthcare Regulatory Excellence on a project commissioned by the Department of Health designed to identify how each of the regulators could bring about a more modern and efficient system of adjudication.

### 3. THE GMC'S PROPOSALS FOR REFORM

3.1 At the heart of the GMC's plans is the establishment of its own Medical Practitioners Tribunal Service (MPTS). There is much to welcome in these plans, currently out for consultation. They are clearly based on OHPA's own intentions to reconstitute proceedings in line with best practice in other tribunals.

3.2 However, it is questionable whether the GMC has successfully designed governance arrangements that will satisfy the need to separate its tribunal from the day-to-day management of the GMC. By the very nature of its establishment the MPTS cannot be fully independent of the GMC. The challenge therefore is to create a governance structure that will go as far as possible to establish the independence of its judicial functioning, and to protect it from the pressures that would otherwise arise in simply being a department of the GMC, the very body that is bringing proceedings before it. For example, should there be a separate board for the MPTS that would sit between the chair of the MPTS and the GMC to assess performance, set remuneration, etc? How will the structure ensure that sufficient resources will be allocated to the MPTS out of the GMC budget? The current proposal that the MPTS should report directly to Parliament, while not improper, is unusual; it is not

one placed upon other independent tribunals. Parliament may find it strange to receive reports from this body but from no other professional disciplinary tribunal. We also wonder whether this line of accountability is consistent with the idea that the MPTS should be held to account via twice-yearly reports to the Council of the GMC.

3.3 The intended provision to allow the GMC to appeal against decisions made by the MPTS is also unusual and may be controversial. Given that the MPTS is being set up within the GMC, the criticism may be made that the GMC is seeking a right to appeal against “its own decisions”.

3.4 Nor is it clear by what mechanism—or over what timescale—the other regulators will learn from the GMC’s experience. Without such a driver and a clear timetable, it must be doubtful that the Government’s anticipated “environment for more consistent approaches and collaborative thinking” will amount to very much in practice.

#### 4. THE NEED FOR REFORM WITHIN THE NMC

4.1 Notwithstanding our concerns in regard to some of their specific plans, the GMC has demonstrated both thought and energy in developing its proposals for the MPTS. Indeed, their evident willingness to learn from OHPA’s intended approach demonstrates an openness to new ideas that is to be commended. In contrast, it is disappointing that to date the NMC has not exhibited a like sense of urgency.

4.2 It is self-evident that any failures on the part of nurses can pose as great a threat to public safety as those of doctors. For that reason alone, it would be unsatisfactory if the disciplinary arrangements for nurses and midwives should lag behind those applied to doctors.

4.3 It has been our experience that those representing nurses have regularly complained that they are judged more harshly than doctors for similar infractions. Had OHPA eventually taken over all health and social care disciplinary hearings, this problem of inconsistency would have been resolved. Indeed, it was perhaps for this reason that both the Royal College of Nursing, and UNISON—the union representing many nurses—argued strongly that OHPA should not be abolished.

4.4 In its most recent performance review report (*Performance review report 2009/10: Enhancing public protection through improved regulation*, July 2010) the CHRE commented on the NMC’s FtP system in the following terms: “we remain concerned about the customer service provided by the fitness to practise department and the quality and consistency of decisions made and recorded by fitness to practise panels”. We are not aware of any more recent analysis of NMC FtP processes or decisions.

4.5 In sum, there is a very strong case for the NMC to undertake the root-and-branch reform of its FtP processes that the GMC has now initiated. While the Government’s decision not to proceed with OHPA (assuming that the relevant clause in the Health and Social Care Bill is enacted) inevitably means that each regulator must reform its own system in piecemeal fashion, that is no reason for the NMC to lag behind the GMC and others.

June 2011

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### Written evidence from the Council for Healthcare Regulatory Excellence (GMC 10)

#### THE GENERAL MEDICAL COUNCIL AND THE NURSING AND MIDWIFERY COUNCIL

##### 1. SUMMARY

1.1 Based on our role overseeing and scrutinising the health professional regulators, the Council for Healthcare Regulatory Excellence welcomes the opportunity to contribute to the Committee’s consideration of the performance of the General Medical Council and the Nursing and Midwifery Council.

##### *CHRE’s oversight of the health professional regulators*

1.2 CHRE scrutinises the work of the UK’s nine health professional regulatory bodies in three ways. We review all final decisions made by regulators’ fitness to practise committees and panels. In the last financial year we reviewed over 2000 cases. Second, we audit the initial stages of regulators’ fitness to practise processes. We look at a sample of the decisions made by each regulator to close a case without referral to a formal hearing in front of a fitness to practise committee. Third, we review the performance of the regulators on an annual basis against agreed standards of good regulation. Our reports are updated with recent figures shortly before publication and so represent up to date assessments of the regulators’ performance.

##### *General Medical Council*

1.3 In CHRE’s view, the GMC performs well. It demonstrates excellence in several areas across its regulatory functions against a background of significant change. The GMC has an impressive commitment to continuous improvement, even in areas where it was already performing to a good standard, and to addressing challenges in medical regulation.

1.4 However, we believe that it is important that the well-established principles of good regulation are not overlooked as regulatory policy and practice develops. While respecting the challenges posed by both the increasing number of complaints about doctors and the decision not to proceed with establishing the Office of the Health Professions Adjudicator (OHPA), we believe that refinements are needed to the GMC's recent proposals to alter their approach to management of fitness to practise to enable them to continue to meet their regulatory objectives. In particular we recommend that decisions at the end of the investigation stage of fitness to practise proceedings are made in a transparent and open manner, and that the GMC reconsiders its proposal to seek the power of appeal against final fitness to practise decisions of the Medical Practitioners Tribunal Service.

#### *Nursing and Midwifery Council*

1.5 CHRE considers that the NMC demonstrates good performance in some but not all areas of professional regulation. Persisting concerns about the performance of the NMC's fitness to practise function have prompted two additional reviews by CHRE over the last three years. The relatively high profile of this area of professional regulation means poor performance can undermine public confidence both in the profession and the system of regulation.

1.6 Based on the outcome of the most recent review, published in January 2011, we are satisfied that the NMC's Chief Executive and Director of Fitness to Practise have a good understanding of the necessary areas for improvement and recognise the impact that the NMC's current performance in this area has on public protection. However, we consider that there will only be real improvement in the NMC's performance within fitness to practise once the improvement plans are fully implemented. The NMC has agreed to provide us with quarterly updates as to the progress made in each of the areas for improvement, and we will also be monitoring the impact of the recent changes in our annual performance review and our audit of decisions to close cases without referral to a final fitness to practise hearing.

1.7 The NMC is a large organisation with many demands on its attention and resources. It is our view that it must stay focused on its core regulatory responsibilities if it is to deliver the necessary improvements and thereby protect the public.

## 2. INTRODUCTION

2.1 CHRE promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies<sup>19</sup> that set standards for training and conduct of health professionals. We share good practice and knowledge with the regulatory bodies, conduct research, and promote the concept of *right-touch regulation*.<sup>20</sup> We advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

2.2 We welcome the Committee's interest in the performance of the GMC and the NMC and hope that the evidence and analysis we have gathered through our work since 2003, across our annual performance reviews and our oversight of fitness to practise decision making, will be of interest as you scrutinise these organisations.

#### *Annual Performance Review*

2.3 Our performance review standards describe how good regulation promotes and protects the health, safety and well-being of patients and other members of the public, and maintain public confidence in the professions. Every year we assess the performance of the regulators against these standards across the four functions of professional regulation:

- Standards and guidance
- Registration
- Education and training
- Fitness to practise.

Our assessment is a statutory report and is laid before Parliament in late June/early July each year.<sup>21</sup> This publication, as with all our work, builds on evidence supplied by the regulators and third parties and is continuously revised and updated in correspondence with the regulators before publication.

<sup>19</sup> General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health Professions Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland.

<sup>20</sup> Right-touch regulation means always asking what risk we are trying to regulate, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and high-quality healthcare. It is the minimum regulatory force required to achieve the desired result.  
CHRE. 2010. *Right-touch regulation*. Available at [http://www.chre.org.uk/\\_img/pics/library/100809\\_RTR\\_FINAL.pdf](http://www.chre.org.uk/_img/pics/library/100809_RTR_FINAL.pdf) [accessed 21 February 2011]

<sup>21</sup> The 2010/2011 Performance Review will be laid before Parliament on 29 June 2011. We are sure that our report would have been of great assistance to the committee in your current inquiry, providing you with up to date information on the performance of the regulators against agreed standards, drawing on information from third parties and complaints. Therefore it is with regret that our evidence will not be able to refer to this most recent assessment of these regulators' work as it will be unpublished at the time the Committee meets.

### *Fitness to practise*

2.4 Fitness to practise is the most high profile of a regulator's functions and usually follows a three stage process once a complaint has been received:

1. A decision as to whether a complaint should be investigated
2. An investigation into the allegations, and a decision made as to whether the allegation should be heard by a fitness to practise panel
3. A panel hearing to consider the evidence, determine whether a professional's fitness to practise is impaired and, if so, which sanction (if any) should be applied.

2.5 Public protection relies on regulators taking fair, proportionate and timely action when a registrant's fitness to practise is called into question, and it is crucial for maintaining public confidence in the professions and their regulation. An effective fitness to practise process has the following attributes:

- It protects patients from harm
- It maintains public confidence in the profession
- It maintains public confidence in the system of regulation
- It ensure that registrants are treated fairly
- It ensures that registrants have confidence in their regulator.

2.6 We review the decisions of all final fitness to practise panels in the interests of the public under our powers in section 29 of the National Health Service and Reform and Health Care Professions Act 2002. This power allows us to refer cases to the High Court if we believe the final decision is unduly lenient and it is in the public interest to do so. We also audit the initial stages of the fitness to practise processes. We look at cases that were closed without referral to a formal hearing by a fitness to practise panel to ensure that the regulators' decisions protect the public and maintain public confidence in the professions and system of regulation.

### 3. THE PERFORMANCE OF THE GMC

3.1 In our 2009–2010 review we concluded that the GMC was performing well, demonstrating excellence in several areas across its regulatory functions against a background of significant change. The GMC has an impressive commitment to continuous improvement, even in areas where it is already performing to a good standard, and to addressing challenges in medical regulation.<sup>22</sup> Particular examples of excellent performance include:

- Setting standards and developing guidance
- Patient and public involvement in the development of standards and guidance
- A comprehensive public facing register which details registrants' fitness to practise history
- Patients' help website and the virtual hearing room.

3.2 Our audit of the decisions taken about the initial stages of fitness to practise, published in March 2011,<sup>23</sup> concluded that the GMC has a well-managed system of casework with no evidence of significant risks to patients or to the maintenance of public confidence in the system of regulation or the profession. They have a robust initial casework system that leads to good decisions that are properly communicated and recorded. We were pleased that the few issues of slight concern that we found in our audit were addressed by the GMC through a revision of policies and procedures.

### *Future developments in fitness to practice at the GMC*

3.3 The Committee will be aware that the GMC are currently consulting on a number of proposals to reform how they handle fitness to practise complaints. Notwithstanding our assessments of the GMC's performance, we would like to draw the Committee's attention to two particular challenges we foresee arising from these proposals.

### *Transparency of decision making*

3.4 The GMC has proposed significant changes to the way they handle the end of the investigation stage of fitness to practise processes.<sup>24</sup> The proposals involve greater discussion between the GMC and the doctors under investigation to encourage them to accept measures appropriate to protect the public thereby removing the need for public hearings. **These proposals represent a radical change of approach to adjudication in**

<sup>22</sup> CHRE. 2010. *Performance review report 2009/10: enhancing public protection through improved regulation*. Available at: <https://www.chre.org.uk/satellite/311/> [accessed 6 June 2011]

CHRE. 2011. *Fitness to practise audit report: audit of health professional regulatory bodies' initial decisions*. Available at: <https://www.chre.org.uk/satellite/387/> [accessed 6 June 2011]

<sup>23</sup> CHRE. 2011. *Fitness to practise audit report: audit of health professional regulatory bodies' initial decisions*. Available at: <https://www.chre.org.uk/satellite/387/> [accessed 6 June 2011]

<sup>24</sup> General Medical Council. 2011. *Reform of the fitness to practise procedures at the GMC—changes to the way we deal with cases at the end of an investigation*. Available at: [https://gmc.e-consultation.net/econsult/consultation\\_Dtl.aspx?consult\\_Id=161&status=3](https://gmc.e-consultation.net/econsult/consultation_Dtl.aspx?consult_Id=161&status=3) [accessed 6 June 2011]

**fitness to practise proceedings.** We are conscious that if implemented, they may well lead to other regulators that we oversee adopting similar routes.

3.5 The decisions that are currently made by GMC panels are (generally) public documents which clearly explain:

- The facts that the GMC allege took place
- Which of those facts have been found proved and why
- Whether the facts that have been found proved amount to one of the statutory grounds on which a doctor's fitness to practise may be impaired
- Whether the doctor's fitness to practise is currently impaired, and if so, the reasons why (including assessing any risk of future repetition)
- Whether a sanction should be imposed, and if so, which one and why.

The decisions therefore act as a clear public record of what the individual doctor did wrong, and why the GMC has decided to take any action to restrict his or her ability to practise as a result. **Such transparency is a major component of public trust in regulation.**

3.6 We regard the production of such high-quality, clearly reasoned decisions as an essential output of the GMC's fitness to practise process—which means that the doctors involved (as well as their employers) have access to a clear account explaining why the panel decided to impose a particular sanction. It is also important to complainants in individual cases that there is a full record of what happened, and of the GMC's reasons for the decision it has taken.

3.7 We think it will be difficult to see how public confidence would be maintained if decisions are taken by GMC staff, without any independent external scrutiny, particularly if detailed reasons are not published. While we are sympathetic to the need to find alternative means of handling a growing number of complaints about doctors' fitness to practise in a fair and proportionate way, we are concerned that these proposals threaten to undermine public confidence in the GMC. **We consider that public confidence in the GMC's regulatory process will only be maintained if there is adequate transparency of decisions made about doctors' fitness to practise.** We are concerned that making changes to this stage of the fitness to practise process risks damaging public confidence in the GMC, as well as causing concern and distress to complainants.

#### *Duplicating roles and responsibilities*

3.8 Following the Government's decision not to proceed with the establishment of OHPA, the GMC have introduced proposals to establish the Medical Practitioners Tribunal Service (MPTS). As part of this package of reforms to the adjudication stage of fitness to practise, the GMC are proposing they acquire the same power of appeal as CHRE holds under s29 (see section 2.6 above) to pursue appeals against unduly lenient decisions of fitness to practise panels. We understand this is intended to demonstrate the independence of the MPTS from the GMC.

3.9 In our view, rather than establishing a sense of independence, we believe it would undermine public confidence in regulation if the GMC was to acquire this power to appeal. There would appear to be a financial and reputational disincentive for the GMC to appeal tribunal decisions, as the costs on both sides would be funded by registrants and any appeal could reflect negatively upon the MPTS. It would also unnecessarily duplicate the powers that CHRE hold in this area.

3.10 It cannot be an appropriate use of resources, or a satisfactory development of roles and responsibilities, if two organisations are given the power to appeal the same decision on the same grounds and it offers a considerable potential for confusion in the future. We can see no benefit in the GMC holding this power, either for those involved in the individual cases, for wider public confidence in the GMC or for the sector as a whole.

## 4. THE PERFORMANCE OF THE NMC

4.1 In 2008 CHRE was asked by the Minister of State for Health Services to expedite our annual performance review and address "the central question of whether the NMC is fulfilling its statutory duties". At that time we found six areas of significant weakness in the management of fitness to practise cases. Since that report<sup>25</sup>, the NMC has been working to address the issues we raised. This activity continues to be a dominant theme in our scrutiny of their performance.

4.2 In the last year, CHRE have published three reports that assessed different aspects of the NMC's performance. We highlight the key findings of each report below before discussing the wider implications.

#### *Performance Review 2009–2010*

4.3 In our Performance Review 2009–2010<sup>26</sup>, we reported that the NMC continued to maintain good performance across a number of its functions, including the development and communication of its standards

<sup>25</sup> CHRE. 2008. *Special report to the Minister of State for Health Services on the Nursing and Midwifery Council*. Available at: [https://www.chre.org.uk/\\_img/pics/library/080611\\_NMC\\_Final\\_Report\\_1.pdf](https://www.chre.org.uk/_img/pics/library/080611_NMC_Final_Report_1.pdf) [accessed 8 June 2011]

<sup>26</sup> CHRE. 2010. *Performance review report 2009–10: enhancing public protection through improved regulation*. Available at: <https://www.chre.org.uk/satellite/311/> [accessed 6 June 2011]

and the efficient processing of registration applications. We also found that it continued to make progress in those areas of weakness identified in our 2008 Special Report, notably around case progression. However, we remained concerned about the quality of customer service and the quality and consistency of decisions made by the fitness to practise panels.

#### *Fitness to practise audit report (2011)*

4.4 In our most recent audit of initial stages of the fitness to practise process we reported our concerns about several weaknesses in the NMC's processes for case management, investigation, decision making and communication.<sup>27</sup> We were also disappointed that weaknesses that had been identified in our previous audit were still evident in the NMC's handling of casework:

- Significant delays and poor case management
- Inconsistent review of new cases to identify risks, and inconsistent prioritisation of high risk cases
- Inadequate information gathering, including sometimes relying on the registrant's uncorroborated account of events
- Poor or no analysis to explain some final decisions
- Poor record keeping and electronic case management, with some key documents missing from files, and inadequate controls on case closure
- Poor links between the computerised fitness to practise case management system and the NMC's registration system, creating a risk that registrants might be able to evade fitness to practise action
- Poor customer service, including inadequate communication with members of the public, and poor information sharing with employers.

4.5 These issues create significant risks that the NMC will not always protect the public or maintain confidence in the professions or the system of regulation. We recommended that the NMC ensures its future plans for its fitness to practise function fully address the weaknesses and risks that we had identified, and are resourced and supported effectively.

#### *Progress review (2011)*

4.6 Alongside our Audit, we also conducted a review of the progress made by the NMC since our 2008 Special Report. This review was carried out at the request of the NMC and was published in January 2011. We found that a number of improvements had been made:<sup>28</sup>

- New premises with specific facilities for fitness to practise hearings
- The introduction of an electronic case management system
- Improved recruitment, training and appraisal of fitness to practise panellists
- The introduction of new posts that will assist with the development of an effective fitness to practise function
- Systems for reviewing and learning from errors.

4.7 However, drawing on third party feedback, evidence submitted by the NMC and our own data and analysis, we continued to have concerns about the work that had still to be done in the following areas:

- Case handling
- Decision making
- Customer care
- Timeliness
- Record keeping
- Overall management of the fitness to practise function.

#### *Reviewing final fitness to practise decisions*

4.8 The legacy of the long-standing problems with the NMC's fitness to practise function can be seen in our ongoing scrutiny of final fitness to practise decisions. In the last financial year we reviewed 2192 cases from across the nine health professional regulators, including 791 from the NMC (36 per cent). After the first review stage we can close a case or ask for further information to support a more detailed review. In 2010–2011 we had to undertake a detailed review of a greater number of NMC fitness to practise panel decisions than decisions made by other regulators.<sup>29</sup> Following the two-stage review process, a case meeting may be convened to consider whether or not a particular case meets the high threshold for a section 29 appeal. In 2010–2011 we

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<sup>27</sup> CHRE. 2011. *Fitness to practise audit report: audit of health professional regulatory bodies' initial decisions*. Available at: <https://www.chre.org.uk/satellite/387/> [accessed 6 June 2011]

<sup>28</sup> CHRE. 2011. *NMC progress review: a review of the NMC's fitness to practise directorate's progress since 2008*. Available at: <http://www.chre.org.uk/satellite/320/> [accessed 6 June 2011]

<sup>29</sup> Even taking into account the fact that NMC panel decisions made up over one-third of all those we received, the proportion of NMC decisions subject to detailed review was still higher than those of other regulators.

held eight case meetings. Of these eight, six concerned NMC cases (75 per cent). The threshold was reached in three of the eight cases and we made referrals to the Courts; all of the three cases were NMC cases.

*Delivering necessary improvements at the NMC*

4.9 We do not underestimate the scale of the work the NMC and its staff have undertaken since 2008 to improve the fitness to practise function, and we recognise that the NMC is currently undertaking a considerable programme of further changes to improve the areas of ongoing deficient performance.

4.10 **These persisting issues have led CHRE to undertake an unparalleled level of scrutiny and involvement over the last three years.** No other regulator within our remit has been subject to two additional reviews over the last three years. Given this, we have taken the unusual step of requesting more frequent updates from the NMC. The NMC is now providing updates on progress to us on a quarterly basis. The first update was provided in April 2011 and has formed part of the data informing our annual Performance Review to be laid before Parliament shortly.

4.11 The problems in the NMC's fitness to practise function over the last few years are well-documented. The high profile of this area of professional regulation means poor performance can undermine public confidence both in the profession and the system of regulation. In our view the NMC's senior management team understand the extent of the changes that are still required, and are now taking the necessary action.

4.12 However, **to deliver these improvements the NMC must maintain its focus on its core regulatory responsibilities.** We are therefore somewhat surprised at the public statements that the NMC has made saying that it wishes to extend its scope and remit and statutorily regulate other groups such as healthcare support workers.<sup>30</sup> CHRE does not believe a valid case has been made to extend statutory regulation to this group of the workforce<sup>31</sup> and we are concerned that the NMC is suggesting this while improvements still have to be made to the delivery of its current regulatory duties.

## 5. FURTHER INFORMATION

5.1 We would be pleased to expand on any of the areas we have discussed if that would be useful to the Committee.

*June 2011*

<sup>30</sup> Nursing and Midwifery Council Press Release. *NMC comment on Panorama's Undercover Care: The Abuse Exposed*. 31 May 2011. Available at: <http://www.nmc-uk.org/Press-and-media/Latest-news/NMC-comment-on-Panoramas-Undercover-Care-The-Abuse-Exposed/> [accessed 7 June 2011]; Santry, C. 2010. *NMC 'single minded' about HCA regulation*. *Nursing Times*. Available at: <http://www.nursingtimes.net/whats-new-in-nursing/news-topics/health-workforce/nmc-single-minded-about-hca-regulation/5010452.article> [accessed 7 June 2011]

<sup>31</sup> CHRE. 2010. *Evaluate before you regulate*. Available at: <http://www.chre.org.uk/media/18/272/> [accessed 7 June 2011]

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